FY 2005

CENTER FOR MENTAL HEALTH SERVICES

BLOCK GRANT APPLICATION

RHODE ISLAND DEPARTMENT OF MENTAL HEALTH, RETARDATION AND HOSPITALS

AUGUST 29, 2004

Duns #: 781912886

Face Sheet

FISCAL YEAR/S COVERED BY THE PLAN

___FY 2005-2007 ___ FY 2005-2006 _X_ FY 2005

STATE NAME: Rhode Island

DUNS #: 781912886

I. AGENCY TO RECEIVE GRANT

AGENCY: Department of Mental Health, Retardation and Hospitals

ORGANIZATIONAL UNIT: Division of Behavioral Healthcare Services

STREET ADDRESS: 357 Barry Hall, 14 Harrington Rd.

CITY: Cranston STATE: Rhode Island ZIP: 02920-3080

TELEPHONE: (401) 462-0455 FAX: (401) 462-6078

II. OFFICIAL IDENTIFIED BY GOVERNOR AS RESPONSIBLE FOR ADMINISTRATION OF THE GRANT

NAME: Craig Stenning TITLE: Executive Director, Division of Behavioral Healthcare

AGENCY: Department of Mental Health, Retardation and Hospitals

ORGANIZATIONAL UNIT: Division of Behavioral Healthcare Services

STREET ADDRESS: 357 Barry Hall, 14 Harrington Rd.

CITY: Cranston STATE: Rhode Island ZIP: 02920-3080

TELEPHONE: (401) 462-2339 FAX: (401) 462-0339

III. STATE FISCAL YEAR

FROM: July 1, 2004 TO: June 30, 2005

IV. PERSON TO CONTACT WITH QUESTIONS REGARDING THE APPLICATION

NAME: Corinna Roy TITLE: Block Grant Planner

AGENCY: Department of Mental Health, Retardation and Hospitals

ORGANIZATIONAL UNIT: Division of Behavioral Healthcare Services

STREET ADDRESS: 357 Barry Hall, 14 Harrington Rd.

CITY: Cranston STATE: Rhode Island ZIP: 02920-3080

TELEPHONE: (401) 462-0455 FAX: (401) 462-6078

Executive Summary

Adult Services

The Department of Mental Health, Retardation and Hospitals is in the process of aligning itself with the new structure of state government as it relates to social services. In 2004, the Governor issued and Executive Order which created the Office of Health and Human Services as the first step in establishing a Health and Human Services Secretariat. The agencies involved include the Departments of Children, Youth and Families; Elderly Affairs; Health; Human Services; and Mental Health, Retardation and Hospitals. The Office strives to balance the commitment to ensure both access and service excellence with sound financial stewardship of limited public health and human service dollars.

MHRH continues to pursue its mission, which is to fulfill its statutory responsibilities to fund, plan, design, develop, administer and coordinate a system of services for identified citizens of Rhode Island with specific disabilities. MHRH is dedicated to achieving the best possible results for its consumers and the taxpayers of Rhode Island within its legislated, annual budget.

MHRH's Division of Behavioral Healthcare (DBH) has worked hard to continue to provide quality services in the face of budget crises and increasing costs. DBH has taken action steps to address the needs it identified in the prior year's Block Grant Plan and developed several new initiatives to improve the current system including:

- The promulgation of new licensing regulations for providers of behavioral health services.
- Addressed new ways to administer the mental health general outpatient funds.
- Addressed homelessness by increasing the stock of low income and transitional housing.
- Built collaborations between MHRH and the Department of Corrections to improve services to the incarcerated mentally ill, or divert the mentally ill from correctional facilities into other programs.
- Restructured the substance abuse general outpatient system via and RFP with a focus on better serving the dually diagnosed.
- Improved the way contracts are written and monitored.
- Improved the collection of Peer Counseling and Advocacy Program outcome data.

The DBH and MHRH remain committed to collecting and reporting data required for the Block Grant Program. In addition the DBH and the Governor's Council use this and other internal data to inform their plans and to make recommendations to the legislature for future programming and the maintenance of needed funding.

Children's Services

The Department of Children, Youth and Families (DCYF) was established in 1980 to centralize responsibility for children's services previously held by the Departments of Human Services, Community Affairs, Corrections, and Mental Health, Retardation and Hospitals.

Children's Behavioral Health/Education is a discrete Division in DCYF. Its location in RI's Child Welfare Agency affords a unique opportunity to integrate Children's Behavioral Health, Child Welfare, and Juvenile Justice Services. Children and families entering the system from any one of these service areas have access to an array of mental health services that may be funded through the individual budgets of the separate units or through Federal funding mechanisms.

DCYF-funded services and programs administered by the eight Community Mental Health Centers (CMHCs), and a wide variety of private vendors, provide the infrastructure for the state's children's mental health system. A network of community-based mental health services for children and their families is now available in all eight of the state's mental health catchment areas. Each of the CMHC's is a newly Certified vendor for the 'new' Children's Intensive Service (CIS) program. In addition, each has a Children's Services Program administered by a Children's Services Coordinator, and each provides a range of services from outpatient services to intensive home-based treatment.

In 1990 the Rhode Island Department for Children, Youth and Families was awarded a National Institute on Mental Health (NIMH) Child and Adolescent Service System Program (CASSP) System Development grant, enabling the Department to enhance its community-based initiative by implementing a state wide children's mental health planning effort at both the state and community level. Grant funding has been used to establish a local coordinating council in each of the state's eight mental health catchment areas, utilizing the CMHC as the lead agency for organization and coordination. A state-wide CASSP coordinating council was formed to coordinate the planning effort. The CASSP mission focuses on its role as an advocate for developing and implementing a coordinated community-based system of care for children with serious emotional disturbances and their families.

CMHCs were issued guidelines that established CASSP membership criteria and operating principles. The membership of the local coordinating councils remains flexible in order to accommodate to the variability that exists among catchment areas. Key participants in each of the LCCs must include parents and other consumers, representatives of public systems providing services to children with serious emotional disorders and their families (Educational, Vocational, Child Welfare, Mental Health, Juvenile Corrections, Health, and Human Service), representatives of private provider agencies, and representatives of the area's minority communities.

A cornerstone of the CASSP planning effort has been the formation of a multi-agency case review team in each of the eight catchment areas. These teams consist of parents and professionals who meet regularly to review some of the most problematic cases that meet the CASSP definition criteria. The multi-agency teams are a resource for both the providers and families, jointly problem solving to identify new or untapped resources which will enable children to remain in the community. Some of the cases that have been reviewed have highlighted major system barriers or gaps that need to be addressed at the state level.

In FY 1994, DCYF received a five-year CMHS project grant of $15,000,000 to develop a comprehensive children's mental health system. This Project REACH program was so successful, the RI state legislature has continued to fund this community-based program (non residential) with state dollars when the Federal funding cycle ended. In FY 2005, the Department will be in the sixth full year of an $8 million program for transition services for youth on probation and leaving the R.I. Training School for Youth (Project HOPE).

Presently the Department of Children, Youth and Families is in the process of applying for two additional Federal grants. One is a SAMSA infrastructure grant and the other is a grant to assist dually diagnosed adjudicated youth transition back to the community from the RI Training School for Youth (RITSY).

Further description of the array of behavioral health programs funded through DCYF will be found in Section III, b, iii that follows.

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PART B. ADMINISTRATIVE REQUIREMENTS, FISCAL PLANNING ASSUMPTIONS, AND SPECIAL GUIDANCE

II. Set-Aside for Children's Mental Health Services Report

Block Grant and State expenditures for children's mental health services are reported by state fiscal years:

BLOCK GRANT FUNDS

	Actual 2002	Actual 2003	Actual 2004	Estimated 2005
Admin/travel	500	1000	0	1000
Youth Pride, Inc.	85,000	85,000	88,000	88,000
State Systems Planner	NA	60000	24,997	57,000
Systems Analyst	NA	NA	NA	60,000
Total	85500	146,000	110,997	206,000

STATE FUNDS, DIVISION OF CHILDREN'S BEHAVIORAL HEALTH

	Actual 2002	Actual 2003	Actual 2004	Estimated 2005
Integrated Services-CIS	3.4 MIL	3.4 MIL	2.8 MIL*	3.4MIL
RCCs	639,312	2.8 MIL	3.4MIL	3.4MIL
ALP	130,000	132,000	132,000	132,000
ILP	413,000	608,000	682,000	682,000
PSN	60,000	60,000	63,000	63,000
Day Treatment	1.02 MIL.	1.02 MIL	1.02MIL	1.02MIL
Project CASSP (Formerly Project REACH)	4,100,000	5 MIL	3.08MIL	3.44MIL
Utilization Review	881,000	1.76 MIL	1. MIL	1 MIL
TOTAL STATE FUNDS	8,885,857	10,998,312	12.18 MIL	13.14 MIL

*Community Mental Health Centers transferred some of their CIS census to other programs in preparation for the new Certified CIS Program (Integrated Services), which began in the spring of 2004. Since their census was reduced, their billings for this service showed a decrease. The Department is anticipating an increased utilization of the new CIS Program during FY 05, which may bring the cost of this program close to the previous year's expenditure.

III. Maintenance of Effort Report (MOE)

MOE information reported by:

State FY _____X_____ Federal FY_____

State Expenditures for Mental Health Services

Actual FY2002	Actual FY 2003	Actual/Estimate FY 2004
$55,332,141	$61,476,594	$61,722,422

Block Grant Expenditures FY 2002, 2003, 2004

RHODE ISLAND DEPARTMENT OF MENTAL HEALTH, RETARDATION & HOSPITALS

CMHS BLOCK GRANT FUNDS ALLOCATED TO MENTAL HEALTH PROGRAMS

PROGRAM:	Actual FY 02	Actual FY03	Estimated FY04	Projected FY05
Catchment Area #1 Northern R.I. CMHC	146,059	108,185	96,774	96,774
Catchment Area #2: Community Counseling Center	131,465	97,375	87,104	87,104
Catchment Area #3: The Providence Center	279,998	196,283	175,579	175,579
Catchment Area #4: Mental Health Services	151,920,	112,526	100,657	100,657
Catchment Area #5: Kent County CMHC	228,874	188,973	176,962	176,962
Catchment Area #6: South Shore CMHC	177,506	150,926	142,917	142,917
Catchment Area #7: East Bay CMHC	110,205	81,628	73,019	73,019
Catchment Area #8: Newport County CMHC	88,141	88,141	58,400	58,400
TOTAL CMHCs	*1,314,168*	*1,024,037*	*911,402*	*911,402*
MHA Federal Block Implementation	550,070	146,639	188,579	188,579
Peer Counseling			220,150	220,150
Department of Children, Youth & Families	99,379	146,189	150,354	150,354
Other Operating	68,016	13,445	7,957	7,957
TOTAL OTHER	*717,465*	*306,273*	*567,040*	*567,040*
TOTAL	2,031,633	1,277,704	1,478,442	1,478,442

State Mental Health Planning Council Requirements

1. Membership Requirements

Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.] describe the composition of the federally mandated Planning Council. The Governor's Council on Behavioral Health will act as this Council. This legislation reads as follows:

Sec. 300x-3. - State mental health planning council

(c) Membership

(1) In general

A condition under subsection (a) of this section for a Council is that the Council be composed of residents of the State, including representatives of -

(A) the principal State agencies with respect to -

(i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and

(ii) the development of the plan submitted pursuant to title XIX of the Social Security Act (42 U.S.C. 1396 et seq.);

(B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;

(C) adults with serious mental illnesses who are receiving (or have received) mental health services; and

(D) the families of such adults or families of children with emotional disturbance.

(2) Certain requirements

A condition under subsection (a) of this section for a Council is that -

(A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and

(B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

2. State Mental Health Planning Council Membership List and Composition

LIST OF PLANNING COUNCIL MEMBERS

Name/Title	Type of Membership	Agency Or Organization Represented	Address, Phone &Fax
Neil Corkery	Adv	Drug & Alcohol Treatment Association of RI	260 W. Exchange St., Providence, RI 02903 521-5759
H. Reed Cosper	SE (Adv)	Mental Health Advocate	John O. Pastore Center, 44 Greendale Court, Cottage 405 Cranston, RI 02920 462-2003
Elizabeth V. Earls	Adv	RI Council of Mental Health Organizations	67 Cedar Street, Suite 1, Providence, RI 02903-1042 273-0900
Cynthia Barry	P	RIMHA	500 Prospect Street, Pawtucket, RI 02865 726-2285, X 12
Carrie Blake	ASMI (Adv.)	RICares	260 W. Exchange Street, Suite 301 Providence, RI 02903 521-5759
Linda Bryan	FMC		485 Weaver Hill Road, W. Greenwich, RI 02817 392-0121
Kai Cameron	FMC	Youth Opportunities, Providence School Department	797 Westminster Street, 3rd Floor Providence, RI 02903 456-9296
Diane Dwyer	Hsg	RI Housing (appt. pending)	R.I. Housing & Mortgage Finance Corp., 44 Washington St., Providence, RI 02903-1721
Sherrel Crown	ASMI		4 Westwood Road Bristol, RI 02809 253-0309
Sandra DelSesto	Prev	Initiatives for Human Development	474 Broadway, Pawtucket, RI 02860 722-9400
Stephen P. Erickson	SE	Associate Judge	Garrahy Judicial Complex, One Dorrance Street, Providence, RI 02901 458-5217
Barbara Inderlin	Adv	St. Francis Chapel	58 Weybosset Street, Providence, RI 02903 331-6510, X 139
Joseph Le	Adv	Social Economic Development Center	270 Elmwood Avenue, Providence, RI 02907 274-8811
Richard H. Leclerc	P	Gateway Healthcare	249 Roosevelt Avenue, Suite 205 Pawtucket, RI 02860 724-8400, X 204
Noreen Mattis	P	Project Link	101 Dudley Street, Providence, RI 02905-2499 453-7618
L. Peter Mendoza	P	Phoenix House	605 Elmwood Avenue, Providence, RI 02907 941-8009
Roseann Mumford	FMA		11 Riverdale Road, Westerly, RI 02891 348-0248
Brenda Nunez	FMC (Adv)	Family Leadership Coordinator	400 Warwick Avenue, Suite 12, Warwick, RI 02888 467-6855

LIST OF PLANNING COUNCIL MEMBERS (CONTINUED)

Name/Title	Type of Membership	Agency Or Organization Represented	Address, Phone &Fax
Tomas Ramirez	ASMI		39 Mallory Court, Cranston, RI 02910 456-9288
Nicki Sahlin Ph.D.	FMA (Adv)	NAMI	82 Pitman Street, Providence, RI 02906 331-3060
Lynn Gacioch	ASMI	NAMI(appt. pending)	82 Pitman Street, Providence, RI 02906 331-3060
Jay Lindgren/ Janet Andersen	SE	DCYF	101 Friendship Street 528-3541 Providence, RI 02903 528-3590
Peter McWalters/ Thomas P. DiPaola	SE	Dept. of Ed.	255 Westminster Street, Shepard Bldg., Providence, RI 02903 222-4600, X 2001
A.T. Wall/Frederic Friedman Ed.D.	SE	DOC	75 Howard Avenue Cranston, RI 02920 462-2611
Jane Hayward/ Frank Spinelli	SE	DHS (RI Voc Rehab)	600 New London Ave. Cranston, RI 02920 462-2121
Kathleen Spangler/ Craig S. Stenning	SE	MHRH	14 Harrington Road, Cranston, RI 02920-3080 462-3201

ASMI: Adult With Serious Mental Illness
FMA: Family Member of Adult With SMI
FMC: Family Member of Child with SED
Adv: Advocate
P: Provider of Mental Health Services
Hsg: Housing
Pre: Prevention
SE: State Employee

PLANNING COUNCIL COMPOSITION BY TYPE OF MEMBER

Type of Membership	Number	Percentage of Total Membership
TOTAL MEMBERSHIP	24	
Consumers/Survivors/Ex-patients (C/S/X)	4	
Family Members of Children with SED	3	
Family Members of Adults with SMI	2	
Vacancies (C/S/X & family members)	0	
Others (not state employees or providers)	6	
TOTAL C/S/X, Family Members & Others	15	63%
State Employees	7	
Providers	4	
Vacancies	0	
TOTAL State Employees & Providers	11	46%

Note: 1) The ratio of parents of children with SED to other members of the Council must be sufficient to provide adequate representation of such children in the deliberations of the Council, 2) State employee and provider members shall not exceed 50% of the total members of the Planning Council, and 3) Other representatives may include public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services.

3. Planning Council Charge, Role and Activities

The following statutes from Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.] describe the responsibilities of the federally mandated Planning Council. The Governor of Rhode Island's Council on Behavioral Health will act as this Council.

Sec. 300x-3. - State mental health planning council

(a) In general

A funding agreement for a grant under section 300x of this title is that the State involved will establish and maintain a State mental health planning council in accordance with the conditions described in this section.

(b) Duties

A condition under subsection (a) of this section for a Council is that the duties of the Council are -

(1) to review plans provided to the Council pursuant to section 300x-4(a) of this title by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;

(2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses or emotional problems; and

(3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

Sec. 300x-4. - Additional provisions

(a) Review of State plan by mental health planning council

The Secretary may make a grant under section 300x of this title to a State only if -

(1) the plan submitted under section 300x-1(a) of this title with respect to the grant and the report of the State under section 300x-52(a) of this title concerning the preceding fiscal year has been reviewed by the State mental health planning council under section 300x-3 of this title; and

(2) the State submits to the Secretary any recommendations received by the State from such council for modifications to the plan (without regard to whether the State has made the recommended modifications) and any comments concerning the annual report.

The Governor of Rhode Island selected the original members of the planning council. The newly formed council established its rules of order and bylaws, which are based on Roberts Rules. Each member serves a three-year term. Members can be reappointed to consecutive terms. If a vacancy occurs public notice is given requesting nominations. The Governor then makes a selection from the nominations. The Council chair may make a recommendation to the Governor regarding the nominations.

The Rhode Island Mental Health Planning Council reviews and evaluates mental health needs and problems in Rhode Island. It stimulates and monitors the development, coordination, and integration of statewide mental health services. The Council serves in an advisory capacity to the Governor. The meetings are open to the public. The schedule of meetings as well as the agendas and meeting minutes are posted on the Department of Mental Health, Retardation and Hospital's website.

Over the past few years, the council has done additional research by way of sub-committees. The Council's sub-committees often include non-Council members with particular expertise or interest in the area of study. The committees have received extensive input from the Mental Health Association,

Rhode Island Council of Community Mental Health Organizations, Mental Health Consumer Advocates, and the Alliance for the Mentally Ill.

The council identified several salient issues for the state during a series of facilitated meetings. They prioritized these issues and have organized themselves into three subcommittees to tackle them. Their formal charges follow:

- Identify the best way to serve high-end mental health service users (typically those using hospital beds) who also have contact with the criminal justice system and/or substance abuse.
- Identify ways to overcome barriers that clients face accessing appropriate services, both when they attempt to "get in the door" and once they are "in the door".
- Review the "Systems of Care Task Force Report," a planning guide for services to children and families across state departments, and make recommendations related to its strengths and weaknesses in serving Rhode Island's youth.

Specific contributions of the Governor's Council toward improvement of services since 1988 include, but are not limited to:

- Recommendations regarding ward closures in the Eleanor Slater Hospital.
- Recommendations for improving case management services.
- Recommendations for improving mental health services for elderly people.
- Recommendations for improving mental health services for children.
- Recommendations for improving and expanding client housing.
- Review and comment on CMHC plans for service development.
- Review and comment on state mental health plan.
- Updating of the state mental health plan, now entitled **Into the Millennium → Recovery**.
- Recommendations for eliminating barriers to care.
- Recommendations to improve consumer choice.
- Recommendations regarding the affiliation of mental health and substance abuse services under behavioral health.

4. State Mental Health Planning Council Comments and Recommendations

Planning Council members were all provided with a copy of this submission to review in August. They were invited to discuss their comments via e-mail, phone or at a meeting held on August 25, 2004. The following letter summarizes their recommendations.

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
Department of Mental Health, Retardation and Hospitals

GOVERNOR'S COUNCIL ON BEHAVIORAL HEALTH
Richard Leclerc, Chairman
C/0 Division of Behavioral Healthcare Services
14 Harrington Road
Cranston, RI 02920 - 3080

TEL: (401) 462-0455
FAX: (401) 462-6078
TDD: (401) 462-6087

August 29, 2004

Honorable Donald L. Carcieri
Governor
State of Rhode Island
State House
Providence, RI 02903

Dear Governor Carcieri:

The Governor's Council on Mental Health is required by P.L. 102-321 to make recommendation to the State regarding the State's application to the Center for Mental Health Services for the Mental Health Block Grant. The governor's Council has reviewed the application for that grant for FY 2004 prepared by the Department Of Mental Health, Retardation and Hospitals in its capacity as the State mental health authority and offers comments contained in this letter.

The governor's Council recommends that the block grant application be submitted to the Center of Mental Health Services as presented.

Sincerely,

Richard Leclerc
Chairman, Governor's Council on Behavioral Health

CC: Jane Hayward, Kathleen Spangler, Craig Stenning, Jay Lindgren, Jr.

5. Public Comments on the State Plan

The public has several opportunities to comment on the state plan. Governor's council meetings where block grant issues are discussed are open to the public and the agendas and minutes of these meetings are available on the website. Block Grant issues are also discussed at budget hearings, which are open to the public. NAMI of Rhode Island receives a copy of the block grant every year, which they now receive electronically so it is easier for them to disseminate. The block grant and implementation report will also be posted on the Department of Mental Health, Retardation and Hospital's website with the State Mental Health Planner's e-mail address to receive comments.

PART C. STATE PLAN

Section I. Description of State Service System

The State of Rhode Island is approximately 48 miles in length and 37 miles in width, totaling approximately 1200 square miles. The 2000 census was 1,048,319, an increase of 44,855, or 4.5 percent, from the 1990 census of 1,003,464. According to the United Way's analysis of 2000 census data, Providence is now New England's second biggest city, due to an 8% population increase in the 1990s, the largest population increase in nine decades. According to this report, "A growing Hispanic population on the South Side is behind Providence's growth; take away that factor, and the city showed almost no increase. Minorities now make up a bigger percentage of Providence's population than non-Hispanic whites. The largest groups of immigrants were from the Dominican Republic, Colombia and Guatemala."[1]

Some other characteristics of the population from the Decennial Census Figures are: 1) 86 percent live in urban areas[2], 2) 85 percent are white, 3) 52.0 percent are female, 4) 23.6 percent are under 18 years of age, and 5) 14.5 percent are 65 years of age or older, 6) there are substantial, and growing communities of color, the largest of which are Hispanic, Asian, and African American.

Again according to the United Way, "[f]ifty-eight percent of Providence residents read at a sixth grade level or below. More than 50,000 Rhode Islanders have less than a ninth grade education. Forty-six percent of employed Rhode Islanders have skills equivalent to less than a high school graduate."[3]

6.8 percent of families and 9.6 percent of individuals have incomes below the poverty level. 11.6 percent of those 65 and over are below the poverty level; 26.5 percent of female householder families are below the poverty level; and 15.3 percent of families with children under the age of 5 are below the poverty level.

Per capita income in 2000 was $21,688. Median household wage and salary income in 2000 was $42,090. The mean retirement income was $16,966.

[1] "The Facts On Line." United Way of Southeastern New England. Vol 13, No 1. May, 2002. Demographics.
[2] 1990 census data
[3] "The Facts On Line." United Way of Southeastern New England. Vol 13, No 1. May, 2002. Education.

The single most dominant characteristic of the state which affects provision of mental health services is not an income or educational characteristic, it is a combination of the size and density of the state and its unique character as a city-state. That factor permits easy identification of catchment areas, acceptance of a single-CMHC service model in each area, a statewide focus on issues, highly developed health, mental health, and social welfare systems, and a tradition of progressive approaches to provision of human services.

This is also a strong tradition of community participation both on the boards of nonprofit provider agencies, and on advocacy groups involved in policy and legislative matters of state government. Interagency coordination is a given. No agency is isolated geographically or organizationally. Current community mental health system legislation encouraging establishment of community mental health boards was initiated in 1962.

The sections that follow describe key components of the mental health system: the state agency, advocacy groups, providers, organization, conceptual philosophy and framework, strengths, and problems.

Department of Mental Health, Retardation and Hospitals

The Rhode Island Department of Mental Health, Retardation & Hospitals (MHRH) was created by statute in 1970 (R.I. General Laws 2-12.1-1 et seq.), as the agency authorized to fund, develop and administer a system of services for the state's citizens with disabilities.

The Department serves hospital patients with chronic, long-term debilitating diseases and medical conditions who generally are uninsured or underinsured. These patients are not clinically appropriate for nursing home care, because a physician has determined that their condition requires hospital-level services. The Department also serves persons with serious and persistent mental illness, emotional difficulty and psychological disorders;

people with developmental disabilities which are attributable to a cognitive or physical impairment, or a combination of cognitive and physical impairments; and persons with a problem of substance abuse that is chronic, progressive and relapsing and results in physical and psychological dependence on chemical substances. Finally, the Department serves all citizens of Rhode Island through promotion of educational and other efforts that focus on prevention of substance abuse, disabilities and disabling conditions through behavioral health initiatives.

In 2004, Governor Donald L. Carcieri signed an Executive Order creating the Office of Health and Human Services, which is designed to facilitate cooperation among the five state agencies including the Department of Mental Health, Retardation and Hospitals, that administer Rhode Island's critical health care and social service programs. The creation of the Office represents the first step in the Governor's plan to institute a cabinet-level Health and Human Services Secretariat --- one of the key recommendations for management efficiency identified by the Governor's Fiscal Fitness program. The Governor noted that a centralized administrative structure will help ensure the realization of more than $70 million in savings throughout the health and human services cluster, and, at the same time, insure more coordinated services for our consumers.

Within the Department of Mental Health, Retardation and Hospitals is the Division of Behavioral Healthcare Services (DBH). DBH is comprised of two program areas**, *Integrated Mental Health Services*** and ***Substance Abuse Treatment and Prevention Services***. The Division of Behavioral Healthcare Services maintains the overall responsibility for planning, coordinating and administering a comprehensive statewide system of mental health and substance abuse prevention, intervention and treatment activities.

Statutory History

Chapter 40.1-1 et seq of the General Laws of Rhode Island of 1956, as amended, provides the statutory authority for the delivery of services for individuals with mental illness, substance abuse or gambling prevention and treatment needs within the Department of Mental Health, Retardation and Hospitals. Chapter 40.1-1 et seq includes specific duties and responsibilities of the Department for the provision of behavioral health services in Rhode Island, as well as requirements of the Governor's Council on Behavioral Health.

The Division of Behavioral Healthcare Services is actively pursuing opportunities to **integrate mental health and substance abuse services within a behavioral health care system to better serve those with co-occurring disorders.** In pursuing this objective, DBH balances this development while recognizing the unique needs within the respective mental health and substance abuse systems, and insuring the provision of quality and accessible care to our client populations within the two systems. Also, the Division continues to **work closely with the criminal justice system (both Corrections and the Courts); child welfare,; the public health care system ;education and other allied human service agencies and organizations.**

The DBH is divided into the following discrete program units:

- Finance and Contract Management
- Planning and Program Development
- Prevention Services
- Substance Abuse Treatment Services
- Mental Health Program Monitoring
- Research, Data and Compliance
- Family and Consumer Affairs

Division of Behavioral Healthcare Services

In FY 2000, DSA was formally linked with the Division of Integrated Mental Health Services (DIMHS) under a new organizational entity of MHRH, the Division of Behavioral Healthcare Services. The mission of the Division of Behavioral Healthcare Services is to improve the care of

people in Rhode Island with mental illness and substance abuse disorders. The manner in which it will carry out its mission is now under development.

Integrated Mental Health Services Unit

The mission of the Integrated Mental Health Services Unit (IMHS) is to improve the quality of life of people in Rhode Island with mental illnesses. It carries out that mission by identifying mental health needs and encouraging provision of a comprehensive and integrated range of services to meet them. The unit's management mission is to implement management support systems to ensure effective and efficient achievement of department policies, goals, and objectives, and to ensure that department resources are utilized in conformance with state and federal laws, rules, and regulations.

IMHS oversees and funds eight community mental health centers (CMHCs), each of which is responsible for providing public mental health services in one of the state's eight catchment areas. IMHS also funds three smaller organizations that provide specialty residential and assertive community treatment services. The primary priority population for state funding in the system consists of adults with serious and persistent mental illness, often referred to as the Community Support Program (CSP) population. IMHS also funds acute mental health hospital services at a psychiatric hospital in Providence.

IMHS reviews and develops standards of quality for community and hospital services; develops survey programs for accreditation, certification and quality standards compliance; develops plans of correction and statements of deficiency; provides training and technical assistance; conducts evaluation studies; monitors relevant policies and procedures; directs investigations regarding hospital and community programs; sponsors consumer advocacy, grievance, governance and rights protection activities; and manages special development projects. IMHS is responsible for the financial aspects of all grants and contracts with community mental health programs. It provides community mental health centers with technical assistance in programming, monitors program aspects of all contracts, and participates in the licensing process.

Although MHRH's purview for mental health services is limited to the adult population, the Department works closely with the Department for Children, Youth and Families (DCYF) on funding and planning activities related to children's mental health.

Substance Abuse Treatment and Prevention Services Unit

Substance Abuse Treatment and Prevention Services (SA) oversees a wide range of substance abuse prevention and treatment services statewide. Funded by a combination of Block Grant, state, Medicaid and other resources, community-based treatment services include a statewide detoxification program, and residential, outpatient, day treatment and opioid treatment services. Substance Abuse funds total $28.8 million, with Block Grant funds of $6.57m allocated toward prevention, treatment and administration, $4.3m in Medicaid, $4.3 in other federal dollars and $13.5m in state revenues. Some services are available in freestanding programs; others are co-located within community mental health centers. Unlike the state's mental health system, MHRH is responsible for substance abuse treatment services for youth as well as adults. SA contracted services are limited to individuals whose incomes are at or below 200% of the federal poverty level and who meet medical necessity criteria for admission. SA also requires the use of ASAM patient placement criteria for determining level of care. Priority populations are determined in part according to federal block grant requirements (e.g.,

pregnant women, injection drug users, individuals with HIV), but also include state defined priorities, such as women involved with the child welfare system who are in treatment working toward reunification; individuals continuing treatment following release from prison, TASC ("Treatment Accountability for Safer Communities") clients, and drug court referrals.

While both systems of care treat individuals with exclusive mental health or substance abuse treatment needs, it is commonly recognized that many clients have concurrent mental health and substance abuse problems. Like other states, Rhode Island has had to face the philosophical, financial and clinical challenges that present obstacles in effectively treating people with co-occurring disorders (COD).

Over the past decade, the "Division of Substance Abuse" has undergone a number of administrative changes within the structure of state government. Historically, alcohol and drug prevention and treatment services came under the purview of MHRH. Between 1992 and 1998, the "Division" became a part of the Governor's office, became a separate state department, and was then transferred to the state Department of Health as a "division" of the public health system. In 1998, the DSA was transferred by Executive Order from the Department of Health to its original setting within MHRH to better reflect the state's need to coordinate substance abuse and mental health treatment under a common administrative body. In 2000, the Divisions of Substance Abuse and Integrated Mental Health Services merged to form the Division of Behavioral Healthcare (DBH), headed by an Executive Director charged with integrating services to better treat individuals with co-occurring disorders. In 2001, legislation was enacted establishing the first Governor's Council on Behavioral Health, replacing the former councils on "Mental Health" and "Substance Abuse". Although these events occurred over the course of an administrative change in the governor's office earlier this year, Governor Donald Carcieri has already demonstrated a strong commitment to providing essential services to people with COD. Prior to taking office in the fall of 2002, he served as a member of the board of one of the state's community mental health centers, where he developed a strong understanding of the needs of clients with mental health and substance abuse problems. Since the election, despite a dismal economic climate, the Governor has been able to limit the budgetary reductions in the area of direct behavioral healthcare services. During the aftermath of a devastating nightclub fire earlier this year which killed 100 victims and injured hundreds more, the Governor personally met with each victim's family and assisted them in accessing needed behavioral health and other services. At a reception held for mental health and substance abuse clinicians involved with fire victims, the Governor personally acknowledged the importance of their counseling efforts. His office, via the Children's Cabinet serves as the management structure for the Division's Prevention State Incentive Grant project funded by CSAP.

Over the past four years the Department has been incrementally facilitating collaboration between mental health and substance abuse staff, and began merging certain functions. The first formal merge created a single Behavioral Health Planning and Program Development Unit, which oversees both the mental health and substance abuse block grants, as well as needs assessment activities, RFP development and grant-writing activity. Staff of the Planning Unit has also begun to collaborate with substance abuse and mental health Information Technology staff to examine common data elements collected and nuances of each separate system. DBH is also addressing combined behavioral health initiatives under its Disaster Preparedness efforts as a result of September 11 events as well as the February Station Nightclub Fire tragedy.

The Division of Behavioral Health also includes a Prevention Unit, which has added the expertise of mental health program staff to its planning team. The Prevention Unit oversees the state's block grant funded prevention programs, the Governor's portion of the Safe and Drug Free Schools and Communities grant, Student Assistance services, a large network of community Task Forces, and a CSAP-funded State Incentive Grant.

Division of Hospitals and Community Rehabilitative Services

The Division of Hospitals and Community Rehabilitative Services plans, develops, and coordinates the delivery of long-term clinical and support services to the frail elderly, persons with chronic disabilities, and long-term psychiatric patients. The Division operates the 628-bed Eleanor Slater Hospital, of which 120 beds were psychiatric and 508 long-term medical-surgical.

The Eleanor Slater Hospital Adult Psychiatric Service is an integral part of a network of hospital-based and community-based services for people who suffer from severely disabling psychiatric illnesses. The system of services of which it is a part provides services to each person in the least restrictive setting possible. Admission to the ESH is considered the most restrictive treatment alternative. An admission is made only when it has been determined that community inpatient facilities are not available or when no other form of residential or outpatient treatment is appropriate. Continued stay at the ESH is considered to be justified only when appropriate community-based inpatient, residential, partial day or outpatient programs, or combination of program are not available.

Division of Developmental Disabilities

MHRH provides a wide range of support services for people with developmental disabilities. Rhode Island Community Living and Supports (RICLAS), operating under the Division of Developmental Disabilities is a state funded program providing day and residential supports. The services are provided by regional and local, private, nonprofit community agencies organized to help people with disabilities develop the daily living and job skills they need to achieve the highest level of independence.

Vocational programs provide a range of competitive and noncompetitive job opportunities as well as evaluation, training and job skills development. Programs encourage people to identify and achieve personal goals, and provide the resources they need to increase their involvement in the community.

Advocacy Organizations

Office of the Mental Health Advocate

The Office of the Mental Health Advocate serves as an independent advocate for mental health system clients regardless of their economic status. The Advocate, appointed by the Governor for a five-year term, provides representation for psychiatric clients in hospitals, group homes and the community-at-large. The Advocate also serves as a source of information regarding client rights and responsibilities in the mental health system.

Mental Health Consumer Advocates

Mental Health Consumer Advocates is a private advocacy group of consumers of mental health services. Its goals are to erase the stigma of mental illness, to improve awareness of mental health issues, and to improve the quality of life of consumers of mental health services.

Alliance for the Mentally Ill (AMI)

NAMI RI, is an affiliate of the National Alliance for the Mentally Ill. It provides support and assistance to family members and consumers using mental health services. It lobbies for support of legislation that would improve the mental health system and the mental health status of mentally ill people. NAMI RI also offers extensive educational courses for children, family members and consumers.

Manic Depressive and Depressive Association of RI,

The Manic Depressive and Depressive Association of Rhode Island is a group of consumers and family members of consumers who run support groups and educational programs for persons living with depression and bipolar disorder. The primary goal of the Association is ensure that the message of recovery reaches all consumers and their families.

Mental Health Association of Rhode Island (MHA)

The Mental Health Association is a nonprofit advocacy and educational agency. It undertakes client, family, and general advocacy through a variety of activities. It develops statewide educational programs designed to raise public awareness of the problems faced by mentally ill people, and to provide basic education in dealing with the stresses of everyday life. It lobbies for support of legislation that would improve the mental health system and the mental health status of the community.

The Rhode Island Council of Community Mental Health Organizations (RICCMHO)

RICCMHO is a responsive resource comprised of nine private, non-profit community mental health organizations in Rhode Island. Established in 1979, the Council is an effective conduit through which member organizations channel their collective expertise to form a united voice of public advocacy for all persons with mental illness.

Rhode Island Disability Law Center, Inc

The Rhode Island Disability Law Center, Inc is part of the national Protection and Advocacy System. It is a private agency organized to serve as an advocate and protector of the rights of developmentally disabled and mentally disabled people. It provides legal representation for people with such disabilities and promotes the development of legislation pertinent to its concerns.

Department of Children, Youth and Families (DCYF)

The Department of Children, Youth and Families was established in 1980 to centralize responsibility for children's services previously held by the Departments of Human Services, Community Affairs, Corrections, and Mental Health, Retardation and Hospitals.

The Division of Children's Mental Health Services is a discrete entity within DCYF. Its philosophy of providing services in the least restrictive environment has driven the development of services and programs.

Although Children's Mental Health Services is a discrete unit in DCYF, its location in a child and family social welfare agency affords a unique opportunity to integrate Children's Mental Health, Child Welfare, and Juvenile Justice Services. Children and families entering the system from any one of these service areas have access to an array of mental health services that may be funded through the individual budgets of the separate units or through Federal funding mechanisms. The children's mental health service system, therefore, provides an infrastructure for statewide mental health services to children and their families. It is integrated with a wide range of services and programs from other service divisions.

DCYF-funded services and programs administered by the eight CMHCs provide the infrastructure for the state's children's mental health system. A network of community-based mental health services for children and their families is now available in all eight of the state's mental health catchment areas. Each of the CMHC's has a discrete Children's Services Program administered by a Children's Services Coordinator, and each provides a range of services from outpatient services to intensive home-based treatment.

In 1990 the Rhode Island Department for Children, Youth and Families was awarded a National Institute on Mental Health (NIMH) Child and Adolescent Service System Program (CASSP) System Development grant, enabling the Department to enhance its community-based initiative by implementing a state wide children's mental health planning effort at both the state and community level. Grant funding has been used to establish a local coordinating council in each of the state's eight mental health catchment areas, utilizing the CMHC as the lead agency for organization and coordination. A statewide CASSP coordinating council was formed to coordinate the planning effort. The CASSP mission focuses on its role as an advocate for developing and implementing a coordinated community-based system of care for children with serious emotional disturbances and their families.

CMHCs were issued guidelines that established CASSP membership criteria and operating principles. The membership of the local coordinating councils remains flexible in order to accommodate to the variability that exists among catchment areas. Key participants in each of the LCCs must include parents and other consumers, representatives of public systems providing services to children with serious emotional disorders and their families (Educational, Vocational, Child Welfare, Mental Health, Juvenile Corrections, Health, Human Service), representatives of private provider agencies, and representatives of the area's minority communities.

Considerable effort has been expended in identifying those who need to be involved, in sharing information, in networking, and in building trust among participants. Part of this planning initiative

has been to encourage a wide range of local participation, and fostering a sense of equal partnership among participants. Local groups have been encouraged to develop interagency models that most effectively meet the needs in communities.

A cornerstone of the CASSP planning effort has been the formation of a multi-agency case review team in each of the eight catchment areas. These teams consist of parents and professionals who meet regularly to review some of the most problematic cases that meet the CASSP definition criteria. The multi-agency teams are a resource for both the providers and families, jointly problem solving to identify new or untapped resources which will enable children to remain in the community. The case review serves several purposes. In some cases, the networking and collaboration has been sufficient to identify needed services and resources in the community, providing the child and family with the necessary and desirable services. In other cases, the local group has advocated at the state level for additional services or funding to enable a child to remain in the community. Some of the cases that have been reviewed have highlighted major system barriers or gaps that need to be addressed at the state level.

In FY 1994, DCYF received a five-year CMHS project grant of $15,000,000 to develop a comprehensive children's mental health system. The goal of this project is to plan and implement non-residential community-based integrated services statewide.

Summary of State's Needs and Accomplishments

Bed Crisis at Butler Hospital

One year ago, Rhode Island was experiencing a psychiatric bed shortage for all consumers of mental health services. Beds in all acute care psychiatric units in the state were usually full, resulting in long patient waits within hospital emergency departments for beds to be made available. This bottleneck in bed availability dramatically impacted the Department of MHRH and the cost of providing psychiatric beds for the uninsured. The usage of state-funded beds for the uninsured had nearly doubled every year for the previous three years, putting additional pressure on budgets already severely constrained. This increase in bed demand matched a corresponding increase in the number of crisis interventions provided by the community mental health centers. While the number of interventions provided to the severely and persistently mentally ill (the CSP population) has remained relatively stable over the last seven years, the number of interventions provided to the uninsured has increased by nearly 40%. This is not balanced geographically, since the heavily urbanized catchment areas are disproportionately impacted by demand from uninsured individuals.

As the economy slowed, the number of uninsured individuals seeking treatment increased. These individuals were often unknown to the community mental health system and first appeared in the emergency department of local hospitals in crisis. These individuals were pressuring not only the monies set aside for hospital beds, but also the public mental health outpatient system. The challenge was to discover ways to provide treatment for the uninsured without additional funding.

Action taken: An internal workgroup at MHRH analyzed the demographic and clinical data available. This group determined that individuals with co-occurring mental health and substance abuse diagnoses largely drove the increase in bed usage. A large number of the individuals were

young, between 18 and 25, and approximately one-third had had involvement with the criminal justice system in the previous year. A substantial proportion of these individuals were homeless.

In concert with a number of partners – our Community Mental Health Organizations, the Department of Corrections and Butler Hospital the Department of MHRH negotiated a contract with the hospital to manage access of all uninsured patients to state-funded beds, and track the status of all emergency department patients awaiting psychiatric hospitalization across the state. Indigent patients were referred to Butler for inpatient care, and patients with Medicaid or private coverage were diverted to open beds wherever available. The contract included incentives for diversion to outpatient settings in the community mental health system, using this single point of entry into the system. There were penalties to the hospital for exceeding a certain number of bed days, but the Department shared the risk with the hospital if the increase in bed days went beyond a certain level (a stop-loss provision). This focus on controlling cost while ensuring care for all who come into the system has resulted in substantial savings this year in hospital costs (on the order of a 16% reduction in costs), which will be used to offset unanticipated expenses in other areas and perhaps program enhancements. Best of all, there is improved collaboration between the hospitals and the Community Mental Health Organizations, ensuring better community/outpatient follow-up. The partnership between the Departments of Corrections and MHRH is also helping ensure better continuity of care.

The system is still confronted with extremely high demand, driven in large part by the almost complete unraveling of the private psychiatric health care system for all but those with sufficient income to pay privately for their care. Many mental health providers will simply not accept private insurance any longer, arguing that it costs them more than they are reimbursed. There is an effort being funded by Blue Cross of Rhode Island to analyze the flaws in the existing system and recommend changes (The SHAPE II study).

In the meantime, the state budget is still under severe constraints, and the public mental health system's outpatient system is still under acute pressure, of which neither condition is expected to abate over the next year.

Adapting to New Freedom Commission Report

In the previous year's Block Grant application, the State identified the need to address the President's New Freedom Commission Report by attempting to implement some of its recommendations.

Action Taken: The Office of Consumer Affairs (OFCA) met with the SAMHSA Administrator on August 26 to devise a plan to implement some of the New Freedom Commission Report recommendations. OCFA, with its Advisory Council, continues to review the New Freedom Commission report. The current direction that the Council is recommending is to involve consumers and family members more strongly in the quality oversight and monitoring process. This is consistent with recommendations contained within the state plan, "Into the Millennium," and the New Freedom Commission Report's recommendation that the mental health care system be consumer and family-driven.

Advisory Council and State Planning Council alike eagerly await the release of the SAMHSA Action Plan, promised for last December, to begin deciding how to prioritize and operationalize other

recommendations. There remain significant needs to be addressed, of which the highest priorities are transition services and treatment for co-occurring disorders.

There has been a great deal of interest among mental health consumers in Rhode Island to address the New Freedom Commission Report Recommendations. They have been and will continue to be involved in the process of implementing recommendations, particularly peer-based services.

Disaster Planning

After the 9/11 terrorist attacks it became clear that it is very important to have a detailed plan to respond to terrorist attacks and other disasters. In the past the Rhode Island emergency Management Agency (RIEMA) has had the primary responsibility for responding to disasters. Rhode Island is currently in the process of networking all kinds of support services to RIEMA's response, including behavioral health services. These efforts include critical incident stress training and regional capacity building to ensure that there is an infrastructure throughout the state that can support victims of disaster. The State has also conducted a few "test disasters" to gauge the responsiveness of the system, but a real disaster revealed that Rhode Island's planning activities paid off. The Station nightclub fire claimed the lives of 100 patrons and workers. With the financial support of SAMHSA, Rhode Island was able to respond quickly and demonstrably to the disaster. Two creative strategies to support victims and their families were to house them in a nearby hotel in the days following the disaster when the bodies were being identified; and the collocation of services that families and victims might need in one location for several weeks following the disaster. The partners who committed staff time to this center included, DHS, MHRH, all of our community Mental Health Centers, the DMV, DCYF, law enforcement, the Red Cross, grief counselors from Massachusetts, clergy, and the RI Funeral Director's Association.

Despite Rhode Island's generally positive response to the disaster, members of the response team realize that more can be done. Rhode island will continue to refine its response system and find solutions to gaps in service that were apparent in this disaster.

Action taken: As of the writing of this application, MHRH has successfully developed a state-wide behavioral health disaster response network and issued a comprehensive behavioral health community disaster plan. The MHRH system has established seven regional behavioral health disaster response teams each led by a senior clinician from the responsible community mental health center serving a specified geographic area. By the end of FY '04, 183 community staff had received a two-day training in Critical Incident, Stress and Trauma. Most had also experienced a half-day training in the Incident Command System used universally in disaster response. Two child-related trainings were also offered: "Critical Incidents, Trauma and Children" and Responding to School Crises. The MHRH Coordinator of Behavioral Health Disaster Preparedness meets monthly with the regional team leaders and their back-up leaders to review system issues, plan training opportunities, plan participation in drills and compare team experiences in local drills and exercises.

Memoranda of Understanding have been signed with the American Red Cross, RI Chapter and are under development with the RI Critical Incident Stress Management (CISM) Team and The Chaplaincy Center. These memoranda address the roles of the organizations in the behavioral health response to any major disaster occurring in RI.

In addition staff have been identified in the three psychiatric hospitals, Bradley, Butler and Eleanor Slater, for membership in internal behavioral health response teams. Training in Critical Incident, Stress and Trauma for those teams will be completed by 9/30/04.

The MHRH Behavioral Health Crisis Management Team continues to meet to advise the Director on system issues, procedures and relationships among the entities involved in the behavioral health response to a major incident.

Redefining Community Support Program Clients

In an effort to better serve the mentally ill clients in Rhode Island, a work group has been convened to reexamine the definition of severely and persistently mentally ill clients eligible for state-funded community support programming (CSP) within this state.

In the past, the CSP designation has been determined primarily by diagnostic criteria with minimal emphasis placed upon the functioning of the client. In an effort to provide a more realistic approach to treatment, the workgroup is examining the feasibility of moving to a more functional assessment with diagnosis as a secondary consideration. The goal is create a definition for CSP that requires treatment providers to consider the needs of each individual client as opposed to simply the diagnosis of each client.

The goals of the group are to gather information on functional assessment forms used by other states, to examine the impact of such a shift upon the client population served by Rhode Island, and the training implications for the community providers should this system be adopted.

Action taken: A revised definition of seriously and persistently mentally ill was developed and test piloted at two Community Mental Health Centers. This definition emphasized functionality of individuals and allowed several new diagnoses to be included. The pilot indicated that a small number of individuals who would not originally have been included as CSP clients would now be allowed services. While this number was small, due to the dramatic cuts that occurred during this budget cycle, MHRH was not able to implement this new definition. MHRH will continue to monitor the impact this definition would have upon the system and hopes to implement these changes in the future.

New Developments and Issues

Adult Services

General Outpatient Funds

The state of Rhode Island allocates 1.7 million dollars toward the treatment of the uninsured individuals needing outpatient levels of care. In the past, these monies have been dispersed based on the geographic needs of each Community Mental Health Center. During the last fiscal crisis in the

state of Rhode Island, a decision was made to further define the use of these funds. Staff from the Department of Behavioral Healthcare are working to define the needs of each CMHC with regard to the uninsured and to work toward a very specific designation of how these funds should be used. The goal is to prioritize individuals who do not meet CSP defined levels of care, but who are at risk for hospitalization.

Disaster Planning

In FY'05, the RI Department of Health will contract with MHRH to provide behavioral health disaster training for the general hospitals of RI and to continue to provide more advanced training for the psychiatric hospitals.

The community emergency response plan will continue to be refined and expanded. Planning goals for '05 include: development of a bio-terrorism annex, increasing the responsiveness of the plan for special populations, the management of mental health volunteers during an incident and developing Memoranda of Understanding with the RI Departments of Health and Children and Their Families and the RI Emergency Management Agency.

Homelessness/Housing

See significant achievements page 43.

MHRH/DOC Collaborations

See significant achievements page 42.

Substance Abuse General Outpatient RFP

Rhode Island has completed several new contracts for our outpatient substance abuse services. These new seven-year contracts were awarded to five prime contractors who will provide services throughout the state. This part of our substance abuse treatment system is being restructured to respond to changing needs in the community for dual diagnosis treatment and to accommodate unfortunate budget cuts. The RFP was developed in early spring and proposals were reviewed and selected in the early summer. While some of the budget cuts that informed this process have been restored, we are still facing future cuts in the next budget cycles. Regardless, this is another good step in the direction of having a more integrated behavioral health system

Contracts

The State is in the process of issuing new five-year contacts to the eight CMHCs within the state. These contracts will update performance requirements to serve state clients. Additionally, all other mental health service providers will be placed on long-term contracts, which will require defined deliverables to receive state funds.

The State has revised internal financial and contract payment process for better compatibility with RISail. A standardized payment process by month is being develop ed to better define our processes and provide more predictability of payments to providers. Finally, the State issued new five-year

contracts for the 39 cities and towns, which regulate the Rhode Island Substance Abuse Prevention Act (RISAPA) funds allocated yearly.

Drastic reduction in block grant funding

The Department received the notification that this year's Block Grant award would be decreased by 6.8 percent on March 10, 2004. This is the largest reduction in the nation; the next largest reduction (in Washington State) was 3.4% (half of our reduction). Our fiscal manager was concerned about the reduction and we had a conference call to discuss the issue with the federal manager of the block grant program and our state representative. We asked for copies of the analysis that informed this reduction. We were informed that the analysis was accurate, and have had to cut funds to our community providers.

Peer Counseling/Advocacy Outcomes

Two of the peer counseling/advocacy sites in Rhode Island are now collecting outcome data. The Office of consumer and Family Affairs has met with the various peer and family-based organizations, and is working out details on what reporting metrics will be used to determine successful outcomes and interventions by these entities. This is being done in concert with these organizations, and requires a change in mindset on their part. The idea of advocacy and recovery support organizations having reportable outcome measures, other than simply a review of expenditures for propriety was novel, but the groups have responded enthusiastically.

Children's Services

- Two new 8 bed Residential Counseling Programs are funded and in the process of becoming operational for 2004.
- A third Service Network for adolescent girls was created in 2004. This brings the total of Service Network slots to 205. These Service Networks provide a statewide no reject/no eject treatment continuum.
- 16 new hospital step down beds in the community are funded, but pending being on line in FY 05-these will be two eight-bed residential programs.
- 23 new regular Foster Homes are in the process of coming on line in FY 05.
- An additional 8-bed Residential Counseling Center (Rumford House) has been funded and is now on line.
- Two four bed community based treatment programs for DD population have been added to the system of care for FY 05.
- A new diagnostic Foster Home capacity, for eight adolescents has been established.
- Project HOPE has been expanded state wide.

- The Children's Intensive Service (CIS) program was converted from a contracted program to one that met Medicaid Certification Standards.

- A new Sex Offender Treatment program was added to the services available at the RI training School for Youth (RITSY). The capacity of this program is 25 beds.

Legislative Initiatives

Adult Services

The Medicaid Buy-In legislation (Bill-H7518) was approved by the General Assembly of Rhode Island. The Bill was initiated by a collaboration of over 35 Rhode Island businesses, agencies, and organizations that formed the Rhodes to Independence Steering Committee. The bill is in response to most disabled individuals fears of entering the workforce and earning significant wages that may result in them losing or jeopardizing their medical coverage or benefits. The fundamental purpose of the Medicaid Buy-In legislation is to allow people with disabilities to be gainfully employed without jeopardizing their medical coverage or benefits.

The Medicaid Buy-In legislation specifically allows the employed individual with a disability to make payments for coverage in accordance with a monthly payment formula. The Department of Human Services is authorized and directed to promulgate rules to establish monthly premium payment for employed individuals with disabilities who opt to participate in the Medicaid Buy-In program. The Department of Human Services formula will count the individual's monthly unearned income in excess of the medically needy income limit, and also count a portion of their earned income on a sliding scale basis to determine each individual's monthly formula. The Department of Human Services will also promulgate rules and regulations for clients who may lose their employment and how they can be maintained in the Medicaid Buy-In program without losing their medical coverage or benefits.

Children's Services

During the last General Assembly session, a sub-committee worked intensively in a collaborative fashion to move along five e major mental health initiatives for children, youth and their families:

1. The Organized System of Care Task Force Report was finalized and presented to the new governor. He promptly assigned it as the primary mission for the Children's Cabinet, which reports directly to the Governor. At this point there have been six committees formed to begin the implementation of this plan. The Governor has appointed a former legislative member and the Governor's Director of Community Relations to chair the System of Care Implementation Committee.

2. In conjunction with major stakeholders in the state- including families, DHS and DCYF - the legislature has gotten a commitment from the three major commercial health insurers in RI to increase their menu of services to children/youth. Commercial Health insurers in RI added a Children's Intensive Service "like" program to their menu of community based mental health services. This commercial program was implemented in the winter of 2004.

3. The DCYF in conjunction with the RI Legislature, the Department of Administration (DOA) and the RI Department of Education (RIDE) is in the process of designing and constructing a new RI Training School for Youth (RITSY). This is RI's only juvenile correctional facility. One of the primary goals of this initiative is to provide more meaningful transition programming to enable delinquent youths to continue their rehabilitation in the community.

4. The RI Family Court has developed a statewide Truancy Court which is assisting families with youth who are experiencing truancy issues. Instead of these cases going in front of the Family Court on a Truancy petition, the families are assisted in getting appropriate community based services to impact the truancy issue.

5. A law entitled Article 23 mandates that families be diverted to community based services for assessments and possibly more long term intervention, before a case is heard in Family court on a Wayward petition. The state has made funds available for this service for the uninsured. To date 75% of the 500 families who have gone through Truancy Court have been diverted from the Family Court system.

Regional Community System

Community Mental Health Centers

The Rhode Island Community Mental Health Law of 1962 encouraged the establishment of community mental health boards. It encouraged them to establish nonprofit agencies to provide mental health services to t heir communities. It made state funding available to them as a match against funds provided by local communities. Eleven agencies were initially formed. Their efforts were concentrated mainly in the provision of outpatient services to the general population.

In 1974, MHRH began to assist those agencies to develop comprehensive programming emphasizing services to severely mentally disabled adults, with particular emphasis on the development of community alternatives to institutionalization. The key factor in this move toward service comprehensiveness was the realignment of the existing mental health service system to make it geographically and organizationally compatible with the requirements of the Federal Community Mental Health Center Act. The realignment resulted in a fully integrated statewide mental health delivery system based on a single comprehensive CMHC in each of the state's eight catchment areas by 1981. CMHCs are now responsible for the provision of all outpatient public mental health services in their catchment areas, and for all admissions to and discharges from inpatient care units.

Each CMHC provides prevention, emergency, general outpatient, and community support services:

- **Prevention** includes a) consultation to other health, mental health, and human service providers to assist them to recognize and address mental health problems among their clients, and b) community education regarding the nature of mental illness and development of a positive attitude toward its prevention and treatment.

- **Emergency Service** is an immediate response by mental health professionals 24 hours per day, 7 days per week, to anyone experiencing a psychiatric emergency. It includes medication and

counseling, referral, face-to-face assessment, and admission to an inpatient unit when necessary. CMHC emergency services made approximately 700 to 1000 face-to-face contacts per month from July 2003 to May 2004 and approximately 600 to 800 telephone contacts per month during that period.

- **General Outpatient** (GOP) Service is provided for people suffering from a degree of mental illness or emotional distress adversely affecting their level of functioning but not severe or long-lasting enough to be disabling. The State served approximately 5000 to 5500 GOP clients per month from July 2003 to May 2004 (some of these clients remained in the system from month to month).

- **Community Support Service** is the formally organized provision of care to seriously mentally ill adults residing in the community. Rhode Island has been a leader in the nationwide movement toward deinstitutionalization of mentally disabled patients since 1977. It has established a community-based treatment system considered among the best in the nation. The provision of services to severely mentally ill adults is the state's main mental health priority.

There are an estimated 44,846 Rhode Islanders with serious and/or persistent mental illnesses that severely limit their functional abilities to the degree that they require assistance in carrying out the activities of daily living. The CMHC network provided a comprehensive array of services to a projected total of 12,030 in FY 2004.

MHRH has had a long-range state mental health plan since 1988. Since 1990, there has been a capital plan identifying the capital requirements for implementing the state mental health plan. Each year MHRH and the Governor's Council on Mental Health identify program priorities for attention by CMHCs.

CMHCs are expected to address state mental health plan service requirements and annual service priorities in their annual plans for service development. Those plans are submitted annually to MHRH. They form the bases of development on which CMHCs are funded for the coming fiscal year.

CMHC proposals for capital development are expected to address the capital plan and the state mental health plan. MHRH reviews CMHC capital plans and bases funding on those reviews. For proposals of a size sufficient for review in the state's certificate of need (CON) program, MHRH provides evaluative comment. The CON process has officially recognized the state mental health plan and the capital plan as the contexts for CMHC development.

Other Community Mental Health Care Providers

Three other organizations provide services to severely mentally ill clients: North American Family Institute provides intensive services in a group home and several apartments. New England Fellowship and Riverwood Rehabilitation Services each operate three group homes, and several mobile treatment teams. Riverwood also operates a day activity program with supported employment opportunities. New England Fellowship operates housing programs, including a supervised apartment and a number of scattered-site apartments.

MHRH operates a Small Business Program to encourage client vocational independence in a competitive environment. The program provided the initial capital investment and annual grants to nonprofit organizations to develop and operate small businesses. Such enterprises employ severely mentally disabled adults. Two businesses are now operating under the Small Business Program: Cookie Place, a bakery, and New Leaf, a plant and garden store.

State Leadership

The publicly-funded mental health system in Rhode Island is based on certain structural concepts:

1. Division of the state into eight discrete mental health catchment areas, each with one community mental health center.

2. Identification of each CMHC as the agency in its catchment area responsible for assuring access of all its clients to a defined array of mental health services. CMHCs are expected to make appropriate arrangements for assurance of client access to those services they do not themselves provide.

3. Utilization of other community mental health providers to meet specialized residential and vocational service needs of clients.

4. Identification by MHRH of populations having high priority for provision of services and identification of services having high priority for development.

5. CMHC provision of services to publicly-funded clients through contractual arrangements identifying volumes of clients and target levels of service to be provided.

6. Retention by MHRH of overall responsibility for assurance of provision of care to severely mentally disabled clients.

7. Reimbursement through MHRH of services provided by CMHCs to severely mentally disabled clients.

The Rhode Island mental health system has a clear structure. In each of the eight catchment areas one agency is directly responsible for the entry of clients into the system and for referral of clients within the system. Each area provides at least the minimum level of all the components of the community support system. The result is a visible and clearly structured system of care with clearly defined and accessible entry points and identification of responsibility. The system is integrated. Clients are able to move from one level of care to another, to the extent services are available.

The system is clear and simple because it was developed by consistent adherence since 1978 to a state plan defining its structure and organizational relationships. A number of planning efforts have been undertaken since that time, all relating to one or another aspect of the basic plan, all in conformity with the basic outlines of that plan. The original planning effort and each of the more specific plans developed following its acceptance involved broad-based participation of the major system constituents, including the Governor's Office, advocates, consumers, and families of consumers.

Participation in the planning process by that diverse constituency developed a strong consensus about system goals and objectives. As a consequence, that constituency has been a major influence in creating a positive environment in Rhode Island for system development.

Those strengths have been augmented by internal MHRH strengths: a clearly articulated and consistent mission, and a singular commitment to seriously mentally ill people. MHRH leadership has focused Division and community efforts toward agreed-upon goals. Division budgets and program implementation activities have reflected the mission and goals.

Section II. Identification and Analysis of the Service System's Strengths, Needs, and Priorities

a.) Adult Mental Health System

Strengths and Weaknesses of the Service System Related to Criterion 1

Rhode Island's mental health system has been successful in dramatically reducing its dependence on institutionalized care for persons with severe and persistent mental illness. Simultaneously, the state has developed an extensive system of community-based care built on a statewide structure of eight community mental health centers, augmented by several specialty agencies.

A projected total of 12,030 persons with severe and persistent mental illness were served in FY 2004 in Rhode Island's community mental health system. The single state-operated psychiatric inpatient facility, the Institute of Mental Health, was merged in FY 1994 with two long-term care state facilities, the General Hospital and the Zambarano Hospital. The merged entity was renamed the Eleanor Slater Hospital. This 628-bed facility now includes 120 psychiatric rehabilitation beds.

Since 1990, the Department of Mental Health, Retardation, and Hospitals (MHRH) has contracted for beds with Butler Hospital, a Brown University affiliated private psychiatric hospital, the state's major provider of acute short-term psychiatric services. The number of beds contracted for has been reduced from 10 to 5 as CMHCs have responded to MHRH incentives to reduce patient utilization.

The successful development of a community-based mental health system in Rhode Island is linked to several factors. MHRH has consistently articulated a mission that identifies community services for persons with severe and persistent mental illness as the highest service priority. Rhode Island's mental health plan, which embraces this mission, was developed through the active participation of key system representatives, including clients, family members, service providers, the General Assembly, and the Governor. The Rhode Island community mental health system has a coherent, visible structure. One CMHC in each of eight catchment areas is responsible for the entry of clients into the system and the delivery of an array of mental health services. Service fragmentation and accountability issues are generally absent due to well-defined and accessible entry points as well as clear identification of responsibility.

One authority, MHRH, has historically controlled funding for both state hospital and community services. MHRH has created financial incentives for CMHC's to serve clients in the community.

The State's objective of achieving maximum impact on client outcomes with available resources is an ongoing challenge with the available resources. However, the State began a systematic measurement of client outcomes in November 1998. Consequently, there is now a set of processes translating measurement into the effective use of resources to improve client outcomes.

The Rhode Island Licensing Standards and Regulations For Mental Health Facilities and Programs requires each client receiving psychotropic medication to receive a yearly physical exam, with consent, if clinically indicated. Each residential program must provide assistance for clients to obtain medical and dental care annually and as needed. All CSP clients are assessed for physical health at intake and during annual treatment plan reviews. Most agencies have arrangements with local physicians and dentists to provide these services. All CMHCs have quality assurance units that regularly monitor and evaluate all medical and dental services.

Case Management Services

Clients who have functional deficits will require case management services. The severity of those deficits and impairments determine the intensity of case management services.

All case managers are exp ected to provide extensive out of office services to community support clients. Case managers are mobile and are expected to provide supports and services in the client's own settings as opposed to the settings of the mental health provider agency[4]. Case managers conduct over half their work outside the office, meeting with clients in their homes, work places and in other settings. They provide extensive personal supports and assist clients in daily living skills, including shopping, budgeting and housecleaning, negotiating with landlords, etc. All direct service staff are expected to take a "hands on" approach and to provide whatever direct assistance is required where clients may need either temporary or ongoing direct assistance. Caseload is determined by workload. The highest current average caseload is 25 to 30 clients per staff member and the lowest average is 8.

Generally, case management services are separated from day program or other services (vocational, etc.). Some organized residential programs perform a case management function so that the case manager changes when the client moves. In other services, case management is a static function that does not change if the client moves from service to service.

Direct service staff see some clients several times daily, and other "low-need" clients as little as once or twice per month. The client, the direct service worker and the supervisor or clinical manager make a joint clinical decision as to how often a client needs to be seen.

Substance Abuse Services

The integration of the MHRH Division of Integrated Mental Health Services and the Division of Substance Abuse Services under the new Division of Behavioral Healthcare Services is proceeding. The planning and financial units are fully integrated, and the other units will be integrated within the

[4] Case management is now entitled Community Professional Supportive Treatment. Case managers are now entitled Community Support Professionals.

year. That integration is now reflected in the way in which services are provided to CMHC clients with co-occurring disorders which has historically been a weakness in the system.

All eight CMHCs are licensed to provide substance abuse services. All 15 mobile treatment teams have substance abuse professionals on their staffs. Intensive training in provision of services to clients with co-occurring disorders has been provided to the staff of one CMHC. Substance abuse services provided to adults with serious mental illness include prevention, intervention, and treatment activities.

All CMHC clients are assessed annually for substance abuse issues. Record audits look at assessments and whether clients identified with substance abuse issues are receiving services within the agency or in coordination with a substance abuse agency.

Reduction of Hospitalization

Current programs to reduce the rate of hospitalization include:

1. Each CMHC is the designated authority for screening of all potential admissions to the state-contracted acute psychiatric beds.

2. CMHC crisis intervention staff deal with clients who are in acute crisis to determine the most appropriate care setting.

3. Fifteen mobile treatment teams provide intensive level services to clients at risk for substance abuse, correctional system contact, hospitalization, etc., in all catchment areas.

4. All adult short-term hospital admissions are now made to seven private hospitals in the community. Only patients requiring stays of over 90 days are considered for referral to the state hospital psychiatric service for long-term care.

Mobile Treatment Team was developed to serve those clients in the system with severe functional deficits, yet can still live in the community with intense case management, vocational and substance abuse services. It is also hoped that the provision of MTT services will reduce crises for this population that may lead to hospitalization.

Mobile Treatment Team service represents a much broader and more intensive set of activities than may at first be appreciated. It focuses on: 1) symptom stability, 2) maintenance of substance-free lifestyles, 3) maintenance of safe, affordable housing, 4) establishment of natural, community-based support networks, 5) minimizing involvement with the criminal justice system, and 6) securing employment.

In 1980 there were 750 long-term psychiatric beds in the state hospital facility. By 1985, that number had been reduced to 250. In 2004, there 104 long-term psychiatric beds.

Strengths and Weaknesses of the Service System Related to Criterion 2

CMHS determines the prevalence of mental illness in all of the states. CMHS estimates that Rhode Island has approximately 44,846 adults with serious mental illness. This figure is used in our performance indicators related to prevalence.

The definition of adults with serious mental illness for FY 2004 is the definition reported in the Federal Register/Vol. 58, No. 96/May 20, 1995/Notice, Page 29425:

Pursuant to section 1912 © of the Public Health Service Act. as amended by Public Law 102-321:

> "adults with a serious mental illness" are persons age 18 and over who currently or at any time during the past year have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified in DSM-III-R that has resulted in functional impairment which substantially interferes with or limits one or more major life activities

These disorders include any mental disorders (including those of biological etiology) listed in DSM - III-R or their ICD-9-CM equivalent (and subsequent revisions), with the exception of DSM -III-R "V" codes, substance use disorders, and developmental disorders, which are excluded, unless they co-occur with another diagnosable serious mental illness. All of these disorders have episodic, recurrent, or persistent features, however, they vary in terms of severity and disabling effects.

Functional impairment is defined as difficulties that substantially interfere with or limit role functioning in one or more major life activities including basic daily living skills (e.g., eating, bathing, dressing): instrumental living skills (e.g., maintaining a household, managing money, getting around the community, taking prescribed medication): and functioning in social family, and vocational/educational contexts. Adults who would have met functional impairment criteria during the referenced year without the benefit of treatment or other support services are considered to have serious mental illnesses.

That definition was summarized and operationalized in the Federal Register, Vol. 62, No. 60/Friday, March 28, 1997/Notices, Page 14928:

> "As previously defined by CMHS, adults with a serious mental illness are persons 18 years and older who, at any time during a given year, had a diagnosable mental, behavioral, or emotional disorder that met the criteria of DSM-III-R…" that has resulted in functional impairment which substantially interferes with or limits one or more major life activities…" The definition states that "adults who would have met functional impairment criteria during the referenced year without the benefit of treatment or other support services are considered to have serious mental illnesses…." DSM-III-R "V" codes, substance use disorders, and developmental disorders are excluded from this definition.

The following criteria were used to operationalize the definition of serious mental illness in the NCS and ECA data:

1. Persons who met criteria for disorders defined as severe and persistent mental illnesses (SPMI) by the National Institute of Mental Health (NIMH) National Advisory Mental Health Council (National Advisory Mental Health Council, 1993).

To this group were added:

2. Persons who had another 12-month DSM -III-R mental disorder (with the exclusions noted above), AND

   Either planned or attempted suicide at some time during the past 12 months,
   OR

   Lacked any legitimate productive role,
   OR

   Had a serious role impairment in their main productive roles, for example, consistently missing at least one full day of work per month as a direct result of their mental health,
   OR

   Had serious interpersonal impairment as a result of being totally socially isolated, lacking intimacy in social relationships, showing inability to confide in other and lacking social support."

That notice stated, "Current data cannot provide estimates of incidence. Additional information needs to be collected in the future."

CMHS now provides the states with an estimate of prevalence, including a range. CMHS estimates that from 3.7 to 7.1 percent of the adult population in any state have serious mental illness. They selected 5.4 percent as the average, which in 2002 in Rhode Island amounted to 44,846 adults (assuming the adult population of 830,477).

Strengths and Weaknesses of the Service System Related to Criterion 4

Services to the Homeless

Homelessness is a condition of people who:

1. Have a primary night-time residence that is a public or private place not designed for, or ordinarily used as a regular sleeping accommodation for human beings; OR

2. Have a primary night-time residence that is a supervised, publicly or privately operated shelter designed to provide temporary living accommodations; OR

3. Are about to be released from an institution or group home without a subsequent residence having been identified; and lack the support networks needed to obtain access to housing.

Imminent risk of homelessness occurs when people will become homeless within a week because they are being evicted from their permanent housing and because they lack the resources and support networks needed to obtain access to housing.

The Division of Mental Health's main effort in provision of services to the homeless is primarily through its grant for Projects for Assistance in Transition from Homelessness (PATH). The grant, for $300,000, targets people who are suffering from serious mental illness and substance abuse and who are homeless or at risk of becoming homeless.

Services include outreach, screening and diagnosis; habilitation and rehabilitation; community mental health; alcohol or drug treatment; staff training; case management; supportive and supervisory services in residential settings; referrals to health services, job training, education, and relevant housing services; housing; and other appropriate services.

The geographic areas of the state served are the catchment areas of the City of Providence and of Newport County. Together, their population represents about one fourth of the state's population. They are the areas with the largest populations of homeless people.

Historically, local PATH programs have delivered all federally required services. Two points of clarification should be presented. The system has moved away from the term "case management." Although staff of local agencies are frequently called case managers, the service they provide is now called "community psychiatric supportive treatment (CPST)." CPST encompasses all of what is traditionally referred to as "case management" plus specific services devoted to symptom education and reduction as well as allowing for CPST services to be delivered to persons in any environment.

The second departure from the required service list is the specific program design requirements. There is enough literature support and practical experience to require a Mobile Outreach Team (MOT) as the specific service delivery mechanism. Therefore, the dollar amount that can be used for "drop-in" services is limited in favor of bolstering the staffing of a MOT that will operate according to assertive community treatment or MTT principals.

Still, at any given time, there are approximately one hundred persons who are homeless and have a severe mental illness. Over the course of a year, there are over 750 episodes of homelessness among persons with severe and persistent mental illness. During the year, an additional 800-900 mentally ill persons are at imminent risk of becoming homeless. The large majority of individuals who are enrolled clients and become homeless are never enrolled or served by PATH funds. These people receive outreach and housing relocation services via the comprehensive network of assertive community treatment teams. National level information indicates that approximately one-half of all homeless persons who have a severe and persistent mental illness also suffer from a co-occurring substance abuse disorder. In terms of street homeless individuals who refuse public shelter, local evaluation data indicates that the level of co-occurring disorders approaches ninety percent.

The most accurate estimate of the potential target population of homeless individuals who have mental health problems is approximately 2,843 individuals, or fifty-percent of the total number of people who visited Rhode Island shelters during the last fiscal year (N=5,686). This total number is based on intake forms filled out by shelter staff each time a new client visits their shelter. Applying national estimates, approximately fifty percent of Rhode Island's total homeless population is in likely need of mental health services. However, the target population for PATH funding in Rhode Island is directed at only those with severe and persistent mental illness. This does leave a clear service gap for those in need of mental health services but whose illness does not meet priority population CSP criteria.

According to self-reported data from the R.I. Emergency Shelter Annual Report: July 1, 2002 to June 30, 2003, 48 percent of the 4,761 people seeking shelter in Rhode Island who had a prior residence in Rhode Island were from the Providence area. The figure below presents the distribution of shelter seekers' prior residences within Rhode Island. Another 925 shelter seekers had prior residences in other New England States (N=417), states outside of New England (N=494) and outside of the United States (N=14).

Another way that Rhode Island serves the homeless is through housing. The Governor of Rhode Island has taken on the issue of homelessness and housing. He created a committee of Department Directors to work together to remove barriers for housing, to work toward an increase in housing, and decrease in the number of homeless individuals in Rhode Island. These quarterly meetings will result in a practical plan for the governor on how to achieve these goals. The group has begun the work of looking at the fiscal impact of being homeless on other systems of care (psychiatric hospitalizations, hospital emergency room visit, Detoxification use). These meetings will continue into the next year.

Service Provision to Rural Areas

The Rhode Island Department of Administration, Office of Systems Planning, is responsible for designating urban, urbanized, and rural areas in the State. It has adopted the Bureau of the Census definition of rural: "Territory, population, and housing units not classified as urban constitute rural."

The 2000 census of Rhode Island reported that 5.9 percent of the 1,048,319 Rhode Island residents lived in rural areas. For the most part, the State's rural areas are in the western part, an area of relatively low population density, although these include the fastest growing regions in the state.

Rhode Island is approximately 48 miles long north to south and 37 miles wide, including Narragansett Bay, east to west. It is often referred to as a city-state, owing to the concentration of people around the Providence-Pawtucket-Warwick metropolitan core, and the ability to go anywhere in Rhode Island in a maximum time of 60 minutes. Given that this 1,200 square mile area has eight mental health catchment areas, it is obvious that travel times within catchment areas are less than that maximum.

The overall catchment area sizes are such that any sub-area classified as rural is by all logic well within the maximum travel time and distance measures for the State as a whole. In addition, some areas defined as rural by the census in Rhode Island are immediately adjacent to more than one urbanized or urban area. The sense of rural in Rhode Island is more one of relatively low population density than of isolation from urban amenities. Under these circumstances, CMHCs in Rhode Island do not establish special programs for rural residents in their areas. Their normal outreach activities address the intention of assuring access by all the catchment area's population.

Two CMHCs reported activities undertaken to serve people in rural areas: 1) networking with other agencies, and 2) use of office space in other agencies. Both reported that the most commonly identifiable aspect of outreach to clients in rural areas was essentially more travel by caseworkers. One additional agency operates its own van for client transport. Two agencies use a regional joint transportation arrangement for social service agencies.

Strengths and Weaknesses of the Service System Related to Criterion 5

The mental health block grant is not distributed to CMHCs for specific activities, it is distributed to be used for those general proposes identified in P.L. 102-351. Block Grant funds are part of the total funding stream to CMHCs, which includes state appropriations and Medicaid as the two major components. In FY 2003, the mental health block grant expenditures represented 1.1% of total expenditures for mental health services in Rhode Island. During the current fiscal year the State was notified that we were to receive the largest percentage reduction in state block grant funding of all fifty states, which Rhode Island is contesting. This cut, in combination with a statewide budget crisis make the greatest weakness in the state system the insecurity of system-wide funding.

For several years since approximately 1993, some funds originally allocated to inpatient services were available for use in the community as patients were transferred to community care. This is no longer the case. The inpatient census has not changed appreciably in the last six years. Community services for the remaining patients with intensive needs are costly and have not been developed conceptually or structurally as yet.

Reallocation of resources in CMHCs has been a policy since 1992, when with no increase in state allocations forthcoming, CMHCs were asked to reallocate resources to assure support of high-priority services. Such procedures also tend to have a limited life span as resources capable of being reallocated dwindle.

State allocation funds are used to match Medicaid funds. One result of the growth in Medicaid reimbursement, and in essentially stable allocation has been a serious reduction in the balance of allocated funds for uninsured clients.

Unmet Service Needs and Critical Gaps within the Current System

The State would like to enhance stakeholder involvement, particularly consumers, in strategic planning for the Division of Behavioral Health. The Office of Consumer and Family Affairs has identified this as a need in the community.

The State would like to implement the recommendations contained within the report from the President's New Freedom Commission on Mental Health. The Federal Government has recommended that all states attempt to incorporate the themes from this report into their service plans.

The State would like to develop a better system for monitoring client complaints against facilities. The lack of this capacity was an issue raised in the federal block grant audit of 2003.

The State would like to improve its emergency response system. After a disastrous nightclub fire, Rhode Island realized that while their emergency response personal did an excellent job of responding to the situation, they were not well prepared to deal with the psychological repercussions for victims, survivors, and first responders. This is something that the State would also like to improve.

The State would like to address the unmet need for residential treatment and group home housing for both the adult population and those aging out of the DCYF system for youth.

The State would also like to address the need for inpatient detox services. It currently is operating at or near capacity and there are times when people are unable to access needed beds.

State's Priorities and Plans to Address Unmet Needs.

The state is planning to build an advisory group to the Office of Consumer and Family Affairs (OCFA). This group will provide real-time feedback on system performance issues, as well as helping to identify and work on strategic issues in system development. In addition, OCFA is providing assistance to the Director of MHRH on reorganization of the department-wide Consumer Advisory Council.

One of the Advisory Group's first tasks will be to identify how best to implement the recommendations contained within the report from the President's New Freedom Commission on Mental Health. Initial activities related to this task include an OCFA facilitating a presentation on the Commission's report with representatives of the National Association of State Mental Health Program Directors (NASMPHD) and the RI Governor's Council on Behavioral Health.

The state has developed a complaint database. 82 complaints have been documented from January 2003- December 2003. Complaints can originate from clients, emergency rooms, licensed behavioral health providers, psychiatric hospitals and family members. Issues range from policy decisions regarding catchment area responsibility to clinical issues of admitting possible clients with co-occurring disorders to either SSTAR or Butler Hospital. Consumer/client issues have focused on follow up treatment concerns for the uninsured outpatient client, as well as more recent complaints regarding discharge and follow up treatment for consumers being discharged from prison. An analysis of these complaints will be conducted to determine if there are patterns of service problems that require correction.

Summary of Recent Significant Achievements

Licensing Regulations

New Licensing regulations will be finalized in 2004. The Mental Health Unit will work with the licensed mental health providers to assure adherence to the regulations. Staff will also be available to review or discuss any issues pertaining to the new regulations.

MHRH/DOC Collaborations

The Department of Corrections within Rhode Island has received several federal grants to further collaboration between state departments. The goal of this collaboration is to decrease the recidivism rates of individuals leaving the prison/jail system within Rhode Island. The Governor of Rhode Island has also taken this issue on as a major initiative for his administration and has assigned a member of his policy staff to the project. Based on the number of individuals with behavioral healthcare issues within the prison/jail system, MHRH has been a key participant in these efforts. The Acting Director for MHRH, the Associate Director for Behavioral Healthcare, and two Public Health Specialist have participated in monthly and bi-monthly meetings, attended workshops/training in Boston, MA and Washington, DC and have provided data to show overlap between the two systems. These collaborations will continue into the next year.

Homelessness/Housing

The Governor of Rhode Island has taken on the issue of homelessness and housing. He created a committee of Department Directors to work together to remove barriers for housing, to work toward an increase in housing, and decrease in the number of homeless individuals in Rhode Island. These quarterly meetings will result in a practical plan for the governor on how to achieve these goals. The group has begun the work of looking at the fiscal impact of being homeless on other systems of care (psychiatric hospitalizations, hospital emergency room visit, Detoxification use). These meet ings will continue into the next year.

Disaster Preparedness

The Intermediate Services grant given by the Mental Health Emergency and Traumatic Stress Services Branch of the Center for Mental Health Services to MHRH to address the mental health needs of the survivors, families and children impacted by The Station nightclub fire (2/20/03) funded a significant outreach, support services, public education and professional training efforts in FY '04-05. A local community mental health center under contract assumed responsibility for a massive outreach and education effort along with staffing of support groups for families, survivors and caretakers. Training efforts for the responder community included: "Helping Burn Survivors Cope with the Present and Generate Hope for the Future", "Trauma: The Mind/Body Connection – The Psychobiology of Trauma and Therapeutic Interventions", "Consideration in Preparation for the First Anniversary of the Station Fire", "Collaborating in Community Crisis Response: Behavioral Health and Pastoral Care", Peer Support Training: A Comprehensive Program for Public Safety Department", "Substance Abuse and Trauma" and a final training event for both providers and survivors, families and children scheduled for 10/22/04. Once the fire was extinguished and the bodies recovered (100 died in the fire), the focus of this tragedy shifted to the medical needs of the burn survivors and the behavioral health needs experienced by all who were affected. The sense of loss, anger, denial, and deep grief remain today for many survivors, families and children. The ability of the behavioral health system to respond to these needs has been gratefully acknowledged by many and hopefully has mitigated the resulting feelings of this tragedy and better prepared many to face the future.

Future System

Rhode Island's public mental health service system continues to face some of the same fiscal and program challenges now faced by many states. Therefore, a description of our hopes for its future must also include the challenges that we face today. Fortunately, our state support for public mental health services has remained constant and has actually increased in order to meet the demand for Medicaid matching funds. Funding targeted only to Medicaid eligible individuals does have a significant down side. Services to uninsured and underinsured individuals, who at any time comprise approximately thirty percent of the seriously and persistently mentally ill adult population, have received no new funding. State funding mechanisms do allow a 'set aside' for non-Medicaid clients, but services to non-insured individuals have withered in both the public and private sectors.

General Outpatient services provided within the state of Rhode Island have been pared back to dangerously low levels. Community Mental Health Centers have maintained some services for clients who do not meet the priority population definition but other major providers have closed or

significantly curtailed outpatient counseling and psychiatric services. This falls on the heals of the loss of a major managed care provider, Harvard Pilgrim, which went out of business in Rhode Island during late 1999. Their behavioral healthcare division serviced almost 8,000 people. Reportedly, only one half of these clients migrated to other providers.

Acute inpatient psychiatric hospital use had skyrocketed over the previous two years, increasing by over one hundred percent. The Division funds acute hospital care for uninsured individuals at a local private psychiatric hospital. While we dramatically slowed the rate of increase through use of an incentive/penalty based contract with Butler Hospital and some tweaks to the outpatient system, we do not have a long-term solution for the problem at this stage. An analysis of the increased use of inpatient resources for this group demonstrates several things:

1. The rate of co-occurring substance abuse disorders among those uninsured individuals hospitalized psychiatrically has increased two-fold.

2. Two out of three individuals who are hospitalized have their first contact with the public mental health system at the point of hospitalization.

3. The availability of in-patient psychiatric beds for all populations (uninsured, Medicaid, privately insured) has outstripped the supply making waits for inpatient care unacceptable.

4. The availability of outpatient services aftercare such as medications and psychotherapy for all populations EXCEPT those served in the Mental Health System's Community Support Services has become generally unavailable on an as-needed basis.

Several steps are being taken to address these issues and create a future system that will better meet the needs of the community. These steps include:

1. Targeting outpatient resources of the public mental health system to those individuals determined "most in need" by virtue of hospitalization history.

2. Examine mechanisms for the funding of "alternatives to hospital level care" such as seven day per week outpatient services, crisis beds and mobile crisis services.

3. Examining and revisiting the delivery of emergency services to make sure those services can provide more than a screening mechanism during evening and weekend hours and can provide active treatment as an alternative to hospital level care.

4. Developing program expertise at the integrated treatment of co-occurring (substance abuse and mental illness) disorders. Work is underway on various fronts in this area including but not limited to the funding of several pilot projects that are now in place, the development of coherent dual disorder licensing standards that will be promulgated in the fall of 2003, training in co-occurring disorder treatment and development of requests for funding to further evidence based co-occurring disorder treatment.

5. Revisiting priority population definitions to review and refine our commitment to those individuals most in need of our treatment services.

6. Refocusing existing services to capitalize on services proven effective based on clinical evidence.

Several other program development options will occur to increase our effectiveness and efficiency. They include:

1. Continuing to refine the variety of outcome measure and mechanisms that the Division and providers use to improve the efficacy of the State's service system. MHRH currently presents providers with regular reports on consumer satisfaction with services and supports via analysis of the Outcome Evaluation Instrument. We are able to track the penetration rates and use of the most appropriate pharmacological agents to assure that clients' receive the most effective treatments possible. By crossing our data with criminal justice information, we are now able to track who among our enrolled clients gets into trouble with the law and to provide appropriate outreach and follow up. Several other benchmarking, data reporting and recovery-oriented projects are under way in the area of information management, and will continue to be utilized and refine in the future State system.

2. Recognition that the failure to recognize mental health issues among certain populations leads to the unnecessary criminalization of these populations. Rhode Island has taken steps to divert individuals with mental health issues from the criminal justice system. The future system will continue to build upon past activities including three major projects that are underway to divert individuals who have severe and persistent mental illnesses or co-occurring substance abuse problems from the criminal justice system into the behavioral health treatment system. These include two court diversion projects and one Jail/ACI based project. In Rhode Island the ACI is both the state's sole jail for the processing and holding of unadjudicated individuals as well as the prison for adjudicated people. We are now in the advanced stages of planning a Crisis Intervention Team (CIT) based on the Memphis, Tennessee model. We have expanded our partnership with the Department of Corrections and the Judicial System, and are currently looking at ways to interface data-sharing with the Homeless MIS system. There are numerous privacy and confidentiality issues to be resolved in this regard.

b.) Children's Mental Health System

i) Comprehensive community-based mental health services

What follows is a description of a newly implemented policy/procedure protocol for the review of all children/youth who are in the care and custody of the Department of Children, Youth and Families (DCYF). It is included in this section to describe how clinical/placement/referral decisions are to be made and how this process will impact access to community based mental health services. This new protocol more clearly details the responsibilities and the relationships between the Care Management Teams (**CMTs**) and Resource Management Team (**RMT**) at the DCYF. The functions of the DCYF Care Management Teams and the Resource Management Team are also described on page 53.

The array of these community based mental health services is described in Part iii.Children's Services, which follows below on page48 .

As of July 15, 2004 DCYF protocol was restructured. In order to successfully implement the processes outlined below, DCYF support staff will provide extraordinary support to the Regional Directors and their staff.

Placement Solutions will make recommendations to Regional Directors/Administrators (RD/Admin) regarding the following:

1. Changes in Placement from In-State or Out-of-State POS Residential to Home with or without wraparound services depending on child/youth/family needs

2. Changes in Placement from In-State or Out-of State POS Residential to DCYF Managed Foster Care with or without wraparound services depending on child/youth/family needs

3. Changes in Placement from In-State or Out-Of State POS Residential to Contracted Therapeutic Foster Care with or without wraparound services depending on child/youth/family needs

4. Changes in Placement from In-State or Out-of- State Purchase of Service (POS) Residential to In-State Contracted Residential with or without wraparound services depending on child/youth/family needs

When Placement Solutions makes any of the above recommendations, it is presumed that these recommendations will be implemented. As soon as possible, the Care Management Team staff and other assigned DCYF support staff will provide support to the RD/Admin to ensure their ability to successfully implement these recommendations. The Regional Director/Administrator may seek assistance from or appeal to the Resource Management Team (RMT) if:

A. After thorough review with the assigned supervisor, worker, whenever possible the family and, as appropriate, the youth, there is strong documented disagreement with the recommendations and/or

B. Impediments to implementation exist which are beyond the capacity of the RD/Admin to address (i.e., recommended service does not exist or is unavailable and that gap is documented).

Shelter Care

- Child Protective Services may place directly during non-standard hours

- RD/Administrator may refer to Placement Unit for Shelter Care after reviewing the case and applying the Priority Standards for Determining Eligibility for Out-of Home-Placement (Priority Standards) (with message that the intent is for placement to be as short as possible with return home unless safety is of continued concern – initial review within 15 days and, if child remains in the shelter after 15 days, a full Care Management Team (CMT) Review by the 45th day of Shelter placement)

DCYF Managed Foster Care

- Referral by Social Caseworker or Probation Counselor to Placement Unit

Group Homes

- Social Caseworker/Probation Counselor refers to RD/Admin who applies Priority Standards, and if met, the RD/Admin refers to the Program Monitor for that program. Program Monitor facilitates the referral. In circumstances where referrals outnumber the available slots for a given program, Program Monitor works with RD/Administrator's to prioritize referrals.

Contracted Therapeutic Foster Care

- Social Caseworker/Probation Counselor refers to RD/Admin who applies Priority Standards, and if met, the RD/Admin refers to contracted Therapeutic Foster Care provider.

Residential Counseling Centers (RCCs) & Networks:

- Requires referral through the Regional CMT but CMT must have attempted all other appropriate options for community-based services.

Extraordinary Exceptions for Requesting Purchase of Service Placement to the Resource Management Team

Requests for exceptions for requesting the RMT to consider either In-State or Out-of State POS Residential Placement shall only be made by the RD/Administrator after all other options for use of community-based services and or contracted out-of-home care have been fully explored by the Regional CMT and deemed unavailable or inappropriate. Clear documentation of this process must be provided to the RMT.

Priority Standards for Determining Eligibility Into Out-of-Home Placement:

1. Abuse or Neglect of a child or imminent risk of harm due to abuse or neglect.
2. A pattern of behavior on the part of a child that is an indication of a danger to self or others.
3. Youth is currently in an unnecessarily restrictive setting (i.e., detention, Training School, psychiatric hospital) and cannot successfully return home.
4. All efforts to maintain a child safely at home have proven unsuccessful.
5. An unavailability of services to safely maintain a child at home and said services cannot be made available within an acceptable time frame.
6. Homelessness.

ii) Mental health system data epidemiology.

There are 224,981 youth in R.I. under the age of eighteen.

The Surgeon General's Report indicates one in five children and adolescents in our state would experience the signs of a DSM -IV diagnosis. In R.I. that translates into a prevalence rate of 44,996.

The surgeon general's Report, page XV, goes on to state that "…only about 5 percent of all children experience what professionals term "extreme functional impairment". This 5% figure, 11,249 in R.I., is the incidence of youth with SED.

iii) Children's Services.

Behavioral Health Services Funded Through the DCYF Division of Behavioral Health/Education are as follows:

Children's Intensive Services (CIS): 1800 (an estimate, CIS re-vamped effective May 04).

This is a program has been redesigned as a Medicaid Certified program. It remains an intensive community based, family centered clinical intervention program designed to develop alternatives to hospitalization or residential placement. This is a statewide program with family choice among nine vendors. There is an open enrollment for vendors, so the number of Certified vendors could increase over time.

Therapeutic Foster Homes: Thirty Therapeutic Foster Homes will continue to be funded for SED youth. An additional 50 are planned for FY 04.

Independent Living Program: This is an Independent Living Program administered by two CMHCS. The focus is on helping older clients develop independent living skills while receiving needed mental health treatment. These provide 16 slots for this level of service.

Prevention:

- There is one prevention program that is targeted for runaway youth and is run by a local agency in the capital city. The focus is on providing the outreach services necessary to prevent involvement with the mainstream mental health system—100 youth.
- **Project Early Start**: there are two agencies that provide in-home services to families with children birth through three and one that deals with children birth through 5. Services include case management, nutrition counseling, child development/education, Parent Aides, and recreation activities. State funds and Medicaid funds are used, there are 116 slots at this point.
- **Comprehensive Emergency Services (CES):** This is an early intervention/prevention service in each of the States 8 mental health catchment areas. The focus is on family preservation with a heavy emphasis on making linkages to appropriate community-based service providers. Two of these programs are administered by CMHCs, facilitating the collaboration between the social service and mental health systems – ll79 Families.

Day Treatment: One of the day treatment programs is for youth with serious emotional disturbances and pervasive develop mental disabilities and is run by a community agency. The other program, administered by a CMHC is for children with serious emotional disorders. The total capacity for these two programs is 24.

Diagnosis and Assessment: 10 Residential

This program is targeted for youth referred by Family Court who require intensive diagnostic services to determine appropriate case planning. There is both a residential and a non-residential component to this program, which strives to link youth to the services necessary to prevent more restrictive placement of court involved youth. DCYF is exploring the possibility of expanding the residential component by 5 male beds. The outpatient piece of this program has the capacity to provide 300 evaluations to the Family Court at the current funding level. Last year 500 Diagnostic Assessment reports were prepared for the Family Court.

Inpatient Services: 60 Beds

State funded inpatient services for children and adolescents are provided by two private non-profit hospitals. The Department provides the funding and the Utilization and Review of straight Medicaid and uninsured youth who require this level of treatment.

Services funded by the Division of Child Welfare are as follows:

The unit of Contract/Planning and standards within the children's Behavioral Health and Education funds about $40 million on services and programs, which include children and adolescents with serious emotional disorders, including the following:

Emergency Shelters: 126 Slots.

There are l5 shelters available across the state for children and youth from birth on. These are temporary placements, which provide both social and mental health services to their clients. Thirteen of the Emergency Shelter Beds in operation in last year were folded into the new NETWORK. So the service capacity for this service remains at last year's level, but the point of entry has been modified for 13 of these beds.

Community Residential (Juvenile Corrections): 87 Beds

There are three facilities in the state providing residential services to youth entering the system through Juvenile Corrections. Mental Health interventions are incorporated into the treatment plan.

Group Homes: 514 Beds

The 514 beds are divided among l3 group homes statewide, serving an average of 8 boys or girls in each facility. These homes provide intensive mental health services to their clients when indicated.

Child Caring Facilities: 70 Beds

The child caring facilities include 6 residential programs for both boys and girls (average 6 clients per facility). Mental health services are available to all clients with serious emotional disorders.

Independent Living: 46 Beds

This program assists adolescents with both social and mental health problems in developing skills necessary to function independently within the community.

Specialized Foster Care: 191 Beds

There are five programs statewide which providing foster care for children and youth with special mental health needs.

In addition to the above services and programs, day hospital services targeted for children and adolescents with severe behavioral, developmental, and emotional disorders are available at an in-state non-profit child and adolescent psychiatric hospital. Additionally, local school departments administer day programs for behavioral disordered children and adolescents, which are available to out-of-district youth.

A range of treatment options is available to children and adolescents statewide. Included in the available treatment options are: outpatient individual, family, and group therapy, intensive home-based services, respite services, behavior management, psychiatric assessment and treatment, including medication management, psychological assessment, inpatient services and sexual and substance abuse treatment.

Management systems

The responsibility for children's mental health moved to DCYF from the Department of Mental Health, Retardation and Hospitals in the mid-1980s to the Department of Children, Youth and Families (DCYF). The responsibility for children's mental health services was incorporated into a specialized unit within the DCYF in 1994.

Children's Behavioral Health and Education was formally established as a Division within the DCYF in 1998. The Division is committed to the development of a continuum of quality services and resources across systems that are easily available to families when they first need assistance with their children. The prevalence of children's behavioral health disturbances has been growing steadily in recent years, and the knowledge base for children's mental and behavioral health has also evolved significantly in its appreciation for the developmental needs and support for children impacted by an emotional or behavioral disturbance.

As the number of children and adolescents needing treatment has grown, it has been an ongoing challenge to operationalize the full range of services necessary to meet this growth. In this past year, the Division has been working with the Department of Human Services, managed care plans, and its community-based providers to analyze utilization data and establish consistent definitions for data collection. This data will create a solid foundation for ongoing development of service capacity and level of need across the continuum.

Education

The Division of Children's Behavioral Health and Education has responsibility for three federal grants in collaboration with the Department of Education to provide education services for children/youth in DCYF custody at the Rhode Island Training School, and at contracted residential treatment facilities that operate their own school programs. These grants are Title I for Disadvantaged Youth, Title II for

Professional Development, and the Individuals with Disabilities Act (IDEA), Part B. Additionally, the Division works collaboratively with the Rhode Island Department of Education and the Office of the Child Advocate's Educational Surrogate Parent program. At any given time, there are approximately 900 children who are represented by the Educational Surrogate Parent Program. This work provides educational representation in special education matters for children whose parents are unable or unavailable to advocate in special education matters.

The Division also provides representation in statewide initiatives relating to the education of children in state care. The focus is to represent children in DCYF care as community members whose needs must be addressed in planning initiatives for educational improvement and reform.

The following are federally grant-funded services:

Project REACH (renamed CASSP): The Department was able to continue to work with the Legislature to allow the full range of the formally Federal Grant funded Project REACH services to continue to be funded at an annualized rate of $3.4 million in state funds. Also, $200,000 in state funds was allocated to provide intensive community based services for uninsured children and youth in the state. This figure is included in Children's Behavioral Health budget in the CASSP line item. An additional $375,000 of state funds this year was allocated to provide Enhanced CASSP Services to be provided through the existing CASSP infrastructure.

Project Hope- Federal Service Grant: The Department in the sixth year of implementation of a six year federally funded service initiative grant, Project Hope. This is a service implementation grant awarded from the Center for Mental Health Services/SAMHSA which provides a single, culturally competent, community based system of care for youth leaving the RI Training School for Youth (RITSY) who have serious emotional problems.

Project Hope has served an estimated 545 youth, 90% of the youth served are male, 77% are age 16 or older with a mean age of 16.4 years and 83% of the individuals served by the Project are youth of color. The project is expected to serve an additional 150 youth in FY 05.

In June 2003, the Project signed a contract with Brown University in the development of a Post-Doctoral Fellowship in Adolescent Forensics. This two year fellowship began on September 1, 2003 and will conclude September 1, 2005. The Fellowship aims to provide the Post-doctoral candidates with a broad training in the area of forensic assessment and treatment, specific to adolescent populations within a self-contained juvenile correctional facility. The fellows will acquire a complete and thorough understanding of the types of disorders typically found in this setting i.e., conduct disorder, learning disabilities, adjustment disorders, substance use disorders etc., understand assessment techniques needed to conceptualize and address the needs of court involved adolescents and understand the full range of clinical services required by this population. In addition they will understand the selection and training of facility and community staff who deliver appropriate treatment milieu to incarcerated adolescents. This program will also expand clinical services available to youth transitioning out of the RITS, as well as provide consultation and training for the community based Project staff.

The Project's employment exploration and skills development training program, Jobs for Ocean State Graduates (JOSG), which began in April 2001, will be entering its fourth year and continues to grow.

The Jobs for Ocean State Graduates program which is managed by the Northern Rhode Island Chamber of Commerce assist youth transitioning from the RI Training School by providing job readiness training curriculum. The JOSG program continues to build a collaborative relationship between the Department, the Provider, Project Hope Local Coordinating Councils, and youth in developing and sustaining effective programming for career/employment preparation, training and placement.

AS220 coordinates the Project's Community Mentoring Program. AS220, is a private not for profit grass roots arts organization located in the capitol city. The AS220 program has experience in working with RITS youth and is providing mentoring services to youth as they transition back into their communities. The Project believes that having the mentoring program in the community will not only be beneficial to the youth in the program but will also enhance the Local Coordinating Council's and the system of care. In addition, the AS220 program continues to actively recruiting mentors who better reflect the cultural and ethnic diversity of the communities in which the youth live.

Project HOPE has served 545 youth to date; 90% of the youth are male; 77% are 16 or older (with a mean age of 16.4); and 83% are youth of color. The projection is to serve an additional 150 youth in FY 05.

New Training Initiatives

- Training has continues for the entire DCYF staff around the issue of Family - Centered Practice.
- The Child welfare Training Institute continue to offer CEU level training for all DCYF staff - and community partners - in a variety of subjects. These include Multi Systemic Treatment, DBT, child development, trauma, sexual abuse, substance abuse and advocacy training. In FY 04 a total of 1,103 staff went though this training.
- All appropriate providers have been trained in the administration of the MCGAS and CAFAS instruments.

The RI Department of Human Services is cross training CEDARR staff, Early Intervention staff and Child Care staff to insure maximum program inclusion of Children with Special Health Care Needs (CSHCN).

Program Redesign

- The CIS program was completely redesigned and made available to all clinically eligible Medicaid children, youth and their families, staring April 2004. These community-based, family - centered services, which are being provided by vendors who are required to meet Certification Standards. These Standards have been developed in conjunction with the major stakeholders in the state including families, providers, out side evaluators and the Department of Human Services, the RI Medicaid Authority.
- By the spring of 2005, all appropriate Children *with Special Health Care Needs* will be enrolled in RIte Care, this is Rhodes Island's managed health care system for Medicaid eligible families This transfer is being accomplished- in a voluntary fashion- with families, DCYF and the Department of Human Service.

- The Department of Human Services continues to develop Medicaid funded family centered programs that are administered through the state wide CEDARR system.

Children's System Needs

Increase the mental health system's capacity for serving youth dually diagnosed with substance abuse and mental health disorders.

Work towards ensuring that the transition planning and implementation of those services between Children's Services and Adults Services can be accomplished in a more seamless fashion. This includes the DD population.

Continue to ensure that the service planning and development activity of various state wide groups, including - the state legislature, CASSP, Comprehensive Evaluation Diagnosis Assessment Referral and Re-Assessment Family Service Centers (CEDARRs), DCYF Care Management Teams (CMTs), DCYF Resource Management Team (RMT), RIte Care (Medicaid Managed health care) and to work closely with families and the major service systems that have a role to play in the system of care for children, youth and families. The Care Management Teams (CMTs) are located in the community, covering the four geographical Child Welfare areas across the state.

*The CMTs are composed of parents, DCYF staff and appropriate staff from the community. The objectives of the CMT process include: bringing families and agencies together for individual planning to meet the needs of children/youth and their families who appear to be in need of high end services including placement; and the identification of unmet service capacity in the community, and then sending this information to the Department, including the RMT.

*The DCYF RMT is composed of top-level department administrators who have several responsibilities including; service planning for specific children/youth who are currently hospitalized or in high-end (POS) placements, this program is called Child-by-Child 2. Another aspect of DCYF RMT is planning on a more macro level for the development of needed community-based programming, and making these recommendations to the Executive Director for needed inter-departmental program development. These service systems include health, education, family groups, MHRH and commercial insurers.

*CEDARRs Family Service Centers (FSCs) are an evolving state wide initiative designed to provide "one stop" shopping for Medicaid eligible families to receive comprehensive evaluation, assessment, diagnosis, referral, re-assessment for and evaluation for complete physical and behavioral health services. There are currently three CEDARR Family Centers in operation, with a fourth going through the certification process. These are state wide in coverage with family choice a paramount part of the design.

Continue to work with the state legislature and other appropriate state agencies to move towards increasing the parity between publicly funded children's services and children's services funded through commercial insurers.

The FY 05 budget supports an average of 103 (27.8%) fewer total Purchase of Service (POS) placements and 24 (48.9%) fewer psychiatric hospital stays. Sections of this FY 05 Block Grant

submission will describe programming activity directed at the reduction in the use of POS and the reduction in the use of psychiatric hospitals.

Section III. Performance Goals and Action Plans to Improve the Service System

a) Adult Plan

Current Activities: Criterion 1

The community Mental Health Center (CMHC) is at the center of MHRH's activities to provide a comprehensive array of community mental health services. MHRH's strategy is to assure development of a flexible, responsive community mental health system in each of the state's eight catchment areas. Some of its goals are oriented toward encouragement of high quality programs in provider agencies. Some are oriented toward the need to improve MHRH internal capacity to plan, develop, monitor, and provide technical assistance to CMHCs. For more detailed information regarding the State's activities related to Criterion 1 please see "Strengths and Weaknesses of the State System Related to Criterion 1" pages 34 to 37.

Goals, Targets and Action Plans for Criterion 1

The primary goal of Criterion 1 is a Status Goal in that it speaks to the desired mental health status of seriously mentally ill people. That goal is at the heart of the MHRH mission to improve the quality of life and reduce the stress of mental illness for those with serious mental illness who are dependent upon public mental health services:

"The functional level of seriously mentally ill adults should be improved to the extent possible."

Criterion 1 addresses service specialization and shifting service emphasis. The emphasis is on the tailoring of services to clients by functional level. Its goal for establishment, implementation, and organization is:

"Seriously mentally ill adults should receive those community support services necessary to maintain or improve their functional level."

The goal is based on the premise that provision of the appropriate mix of services by client functional level will result in a measurable improvement in the overall functional level status of the group of seriously mentally ill adults served. The mix of services provided can be modified to suit the basic

strategy desired. In this instance the basic strategy is to make most effective use of resources expended.

The services that address this criterion focus on 1) linking the major system components more effectively in planning for the future, and 2) achieving maximum impact on client outcome with available resources. All services are designed to enable clients to function outside inpatient or residential institutions, including the services provided in such institutions. The mission of the Office of Mental Health Systems Development summarizes that intent:

"To promote the independence and potential for improvement in the functional level of seriously mentally ill people by planning and monitoring service development and allocating financial resources so as to encourage and guide the establishment of a comprehensive and integrated set of community-based mental health services."

The range of services includes:

	Average Number of Clients Served Per Month		
	Actual Volume	Projected Volume	Target Volume
Support	FY 2003	FY2004	FY 2005
Case Management[1]	4020	3948	3948
Drop-In Center	73	56	56
Rehabilitation			
Psychiatric Rehabilitation	616	501	501
Voc/Ed Assessment	54	26	26
Individual Placement and Support	291	220	220
Supported Work/TEP	429	429	429
Job Finding/Development (Hours.)	3724	456	456
Residential			
Intensive Residential	57	58	58
Specialty Residential	96	98	98
Basic Residential	111	121	121
Treatment			
Crisis/Respite Beds	22	22	22
Emergency Assessment	310	316	316
Mobile Treatment Team	1007	1037	1037
Counseling	1552	1741	1741
Substance Abuse Treatment-OP	190	158	158
Medication Maintenance	2920	3021	3021
Family Treatment	9	7	7

Source: All CSP and a portion of GOP clients (32% for FY03 and 36% for FY04) from the Service Report sent to MHRH by the 8 large CMHC's.

Two performance indicators are used to measure the extent to which establishment, implementation, and organization goals are achieved:

1. Percentage of adult clients who receive Assertive Community Treatment.

2. Percentage of MTT and RIACT clients receiving peer-run, self-help, or day-treatment alternative services.

3. One performance indicator is used to measure the extent to which available service and resource goals are achieved:

4. Percentage of adult CMHC clients served who receive case management services.

5. One performance indicator is used to measure the extent to which reduction of hospitalization goals are achieved:

6. Percentage of MTT clients reporting that they "belong to any social clubs, special interest/activity groups, self-help groups, support groups, etc. in the community that are not sponsored by your mental health agency."

Criterion 1 Mental Health Performance Indicator Descriptions

Criterion 1, Measure 1: Assertive Services

Goal: Seriously mentally ill adults should receive those community support services necessary to maintain or improve their functional levels.

Population: Adults diagnosed with serious mental illness.

Criterion: Comprehensive, community-based mental health system: available services and resources.

Brief Name: Percentage receiving Assertive Community Treatment.

Indicator: Percentage of seriously mentally ill adult clients who receive Mobile Treatment Team Services.

Measure: **Numerator:** The average number of seriously mentally ill adult clients receiving Mobile Treatment Team Services.

Denominator: The average census of seriously mentally ill adult clients receiving services.

Sources of Information: MIS Reporting System

Special Issues: None

Significance: Mobile Treatment Team services have been demonstrated to be a particularly effective means of providing an intensive level of services in a coordinated fashion so as to bring hard to reach clients into the system.

Criterion 1, Measure 2: Case Management Services

Goal: Seriously mentally ill adults should receive those community support services necessary to maintain or improve their functional level.

Population: Adults diagnosed with a serious mental illness

Criterion: Comprehensive community-based mental health system: establishment, implementation, and organization.

Brief Name: Percentage receiving case management.

Indicator: Percentage of adult CMHC client census who receive case management services.

Measure: **Numerator:** The average number of seriously mentally ill adult clients receiving case management services.

Denominator: The average census of seriously mentally ill adult clients receiving services.

Sources of Information: MIS Reporting System

Special Issues: None

Significance: Criterion 7 of P.L. 102-321 address the need to provide case management services to those people who receive substantial amounts of public funds or services.

Criterion 1, Measure 3: Reduction of Hospitalization (CORE MEASURE)

Goal: Serve the needs of the mentally ill in the state funded inpatient beds in the state

Population: Adults with mental illness

Criterion: Comprehensive, community-based mental health system: reduction of hospitalization.

Brief Name: Reduction of hospitalization

Indicators: 30 and 180 day return rates to hospitalization

Measure: **Numerator 1:** Number of readmissions to SMHA funded hospital setting within 30 days of discharge

Numerator 2: Number of readmissions to SMHA funded hospital setting within 180 days of discharge

Denominator: Number of discharges from SMHA funded hospital

Sources of Information: State Hospital data

Special Issues: Rhode Island does not have a psychiatric inpatient hospital rather a general hospital with a psychiatric unit and a private funded hospital with state paid beds.

Significance: The number of patient days utilized by inpatient psychiatric services as an indication of the extent to which community services to replace those days have not yet been fully developed.

Criterion 1, Measure 4: Treatment Team Services

Goal: Seriously mentally ill adults should receive those community support services necessary to maintain or improve their functional level.

Population: Adults diagnosed with serious mental illness.

Criterion: Comprehensive, community-based mental health system: available services and resources.

Brief Name: Treatment team clients receiving client-identified services.

Indicator: Percentage of MTT and RIACT clients accessing peer-run, self-help, day-treatment alternative services, or involved with other socially-oriented community organizations.

Measure: **Numerator:** Number of MTT clients reporting that they "belong to any social clubs, special interest/activity groups, self-help groups, support groups, etc. in the community that are not sponsored by your mental health agency."

Denominator: The average census of MTT and RIACT clients receiving services.

Sources of Information: Outcome Evaluation Survey

Special Issues: Collect data on RI CSP (Community Support Program) population only which does not include all SMI clients

Significance: Client-identified services and social supports have been demonstrated to be a particularly effective in helping clients to achieve recovery.

Criterion 1, Measure 5: Client Perception of Care (CORE MEASURE)

Goal: Seriously mentally ill adults should have a positive perception of their care

Population: Adult CSP (community support population) who are the more seriously mentally ill.

Criterion: Comprehensive, community-based mental health system: available services and resources.

Brief Name: Client perception of care

Indicator: Percentage of adult CSP clients reporting positively regarding access to care, the quality and appropriateness of care for adults, outcomes, participation in treatment planning, and general satisfaction with services.

Measure: **Numerator:** Number of CSP adults in sample responding positively about access to care, the quality and appropriateness of care for adults, outcomes, participation in treatment planning, and general satisfaction with services

Denominator: Number of consumers in sample

Sources of Information: Outcome Evaluation Survey

Special Issues: Collect data on RI CSP (Community Support Program) population only which does not include all SMI clients

Significance: It is important for clients to participate in their treatment plan and be able to express their opinions about their treatment plan. It is also important for both clients and providers to be aware of client's satisfaction with their treatment plan to ensure quality service provision.

Criterion 1 Mental Health Performance Indicator Statistics

STATE MENTAL HEALTH PLAN FY 2005

PERFORMANCE INDICATORS

Population: SMI Adult or SED Children (Circle one)

Criterion I: Comprehensive, Community-Based Mental Health System

(Please start a new page for each of the criteria.)

	FY 2003	FY 2004	FY 2005	%
	Actual	Projected	Objective	Attain
1. Percentage Receiving Assertive Community Treatment				
(Brief Name) Percentage of Clients Census Receiving Mobile Treatment Team				
Value				
IF Rate:	8.8%	8.6%	8.6%	
Numerator: The average number of seriously mentally ill adult clients receiving Mobile Treatment Team Services	1,007	1,037	1,037	
And				
Denominator: The average census of seriously mentally ill adult clients receiving services.	11,361	12,030	12,030	
2. Percentage Receiving Case Management				
(Brief Name) Percentage of Client Census Receiving Case Management				
Value				
IF Rate:	37.9%	34.6%	34.6%	
Numerator: The average number of seriously mentally ill adult clients receiving case management services	4,311	4,165	4,165	
And				
Denominator: The average census of seriously mentally ill adult clients receiving services	11,361	12,030	12,030	
3. Reduction of Hospitalization				
(Brief Name) Reduction of hospitalization				
30-Day Value	10.4%	8.7%	8.7%	
180-Day Value	6.8%	6.6%	6.6%	
IF Rate:				
30-Day Numerator	81	74	74	
180-Day Numerator	53	56	56	
And				
Denominator: Total number of discharges	776	852	852	

STATE MENTAL HEALTH PLAN FY 2005

PERFORMANCE INDICATORS

FOR NEW FUNDING SERVICE MODIFICATIONS

Population: SMI Adult or SED Children (Circle one)

Criterion I: Comprehensive, Community-Based Mental Health System

(Please start a new page for each of the criteria.)

	FY 2003	FY 2004	FY 2005	%
	Actual	Projected	Objective	Attain
4. Treatment Team Clients Receiving Client-Identified Services				
(Brief Name) Percentage of MTT and RIACT clients accessing peer-run, self-help, day-treatment alternative services, or involved with other socially-oriented community organizations				
Value	21.1%	20.6%	20.6%	
IF Rate:				
Numerator: The average number of MTT and RIACT clients accessing peer-run, self-help, day-treatment alternative services, or involved with other socially-oriented community organizations	212	214	214	
And				
Denominator: The average census of MTT and RIACT clients receiving services.	1007	1037	1037	

STATE MENTAL HEALTH PLAN FY 2005

PERFORMANCE INDICATORS

FOR NEW FUNDING SERVICE MODIFICATIONS

Population: SMI Adult or SED Children (Circle one)

Criterion I: Comprehensive, Community-Based Mental Health System

(Please start a new page for each of the criteria.)

Perception of Care	FY 2003	FY 2004	FY 2005	%
	Actual	Projected	Objective	Attain
5a. Percent Reporting Positively About Access				
Value				
IF Rate:	90.4%	89.5%	89.5%	
Numerator:	3020	2992	2992	
Denominator:	3338	3343	3343	
5b. Quality and Appropriateness of services for Adults				
Value				
IF Rate:	91.3%	90.4%	90.4%	
Numerator:	3022	3019	3019	
Denominator:	3308	3337	3337	
5c. Percent Reporting Positively About Outcomes.				
Value				
IF Rate:	73.5%	70.9%	70.9%	
Numerator:	2331	2293	2293	
Denominator:	3170	3232	3232	
5d. Participation In Treatment Planning				
Value				
IF Rate:	78.3%	77.7%	77.7%	
Numerator:	2537	2527	2527	
Denominator:	3239	3249	3249	
5e. General Satisfaction with Services				
Value				
IF Rate:	90.0%	89.9%	89.9%	
Numerator:	3026	3036	3036	
Denominator:	3361	3377	3377	

Additional Criterion 1 Performance Indicator Descriptions

CMHS requested that three additional performance indicators for adults with serious mental illness be included in this report:

1. Percent who are employed,
2. Percent who are living independently,
3. Percent who have had contact with the justice system.

Criterion 1, Measure 5: Percent Employed

The Outcome Evaluation Instrument addresses employment by asking clients the question: "In the past 3 months, did you work a paid job?"

Goal: Seriously Mentally ill adults should receive those community support services necessary to maintain or improve their functional level.

Population: Adults diagnosed with a serious mental illness

Criterion: Comprehensive community-based mental health system: establishment, implementation, and organization.

Brief Name: Seriously Mentally ill adults employed.

Indicator: Percentage of sample of seriously mentally ill adults employed.

Measure: **Numerator:** Number of seriously mentally ill adults employed.

Denominator: Number of seriously mentally ill adults served.

Sources of Information: Outcome Evaluation Instrument

Special Issues: Collect data on RI CSP (Community Support Program) population only which does not include all SMI clients

Significance: Employment is a measure of the extent to which a seriously mentally ill adult is able to function in the community.

Criterion 1, Measure 6: Percent Living Independently

The Outcome Evaluation Instrument does not ask that question. CMHS MIS information asks an objective question about the kind of residence in which a client lives. Independence, however, is a more subjective concept. Consequently, a modified response is provided here. In. FY 2004 data are available from the Outcome Evaluation Instrument in response to the question "How satisfied are you with your current housing arrangement?"

Goal: Seriously mentally ill adults should receive those community support services necessary to maintain or improve their functional level.

Population: Adults diagnosed with serious mental illness.

Criterion: Comprehensive, community-based mental health system: available services and resources.

Brief Name: Satisfaction with housing.

Indicator: Percentage of seriously mentally ill adults reporting satisfaction with housing.

Measure: **Numerator:** Number of seriously mentally ill adults reporting they are "very satisfied" and "somewhat satisfied" with their current housing arrangement.

Denominator: Number of seriously mentally ill adults in sample.

Sources of Information: Outcome Evaluation Instrument

Special Issues: Collect data on RI CSP (Community Support Program) population only which does not include all SMI clients

Significance: Satisfaction with current housing is a measure of the extent to which housing is consistent with client needs and desires.

Criterion 1, Measure 7: Percent Having Contact with Criminal Justice System---

The Outcome evaluation Instrument includes the question "Have you been arrested in the past 12 months?" to address the issue of contact with the criminal justice system.

Goal: Seriously mentally ill adults should receive those community support services necessary to maintain or improve their functional level.

Population: Adults diagnosed with a serious mental illness.

Criterion: Comprehensive, community-based mental health system: establishment, implementation, and organization.

Brief Name: Contact with criminal justice system.

Indicator: Percentage of seriously mentally ill adults who have had contact with criminal justice system.

Measure: **Numerator:** Number of seriously mentally ill adults who have been arrested in the past 12 months.

Denominator: Number of seriously mentally ill adults in sample.

Sources of Information: Outcome Evaluation Instrument.

Special Issues: Collect data on RI CSP (Community Support Program) population only which does not include all SMI clients

Significance: Involvement with criminal justice system is a key outcome measure, especially for the more intensively ill adults. The extent to which involvement is avoided is a measure of a more positive life experience.

Criterion 1, Measure 8: Evidence-Based Practices

Goal: The number of seriously mentally ill adults receiving Family Psychoeducation, Integrated Treatment for Co-occurring Disorders (MH/SA), Supported Housing, Supported Employment and Assertive Community Treatment

Population: Seriously mentally ill

Criterion: Comprehensive, community-based mental health system: establishment, implementation, and organization.

Brief Name: EBP

Indicator: Prevalence of SMI receiving Evidence-Based Practices

Measure: **Numerator:** Number of seriously mentally receiving evidence based practices

Denominator: Number of seriously mentally ill in the community population

Sources of Information: Not yet available

Special Issues: While several agencies provide services based on the EBP models listed under goal, not all EPB measures have been fully defined by CMHS and therefore RI has not taken steps to implement necessary means to collect and report on this information.

Significance: It is important for states to implement systems with programs that are proven effective.

Additional Criterion 1 Performance Indicator Statistics

STATE MENTAL HEALTH PLAN FY 2005

PERFORMANCE INDICATORS

Population: SMI Adult or SED Children **(**Circle one**)**

Criterion I: Comprehensive, Community-Based Mental Health System

(Please start a new page for each of the criteria.)

Performance Measures:	FY 2003	FY 2004	FY 2005	%
	Actual	Projected	Objective	Attain
5. Percent Seriously Mentally Ill (SMI) Adults Employed*				
(Brief Name) Percent SMI adults employed				
Value				
IF Rate:	21.5%	20.4%	20.4%	
Numerator: Number of SMI adults in sample employed	748	695	695	
And				
Denominator: Number of seriously mentally ill adults in sample	3475	3410	3410	
6. Percent SMI Adults Satisfaction With Housing*				
(Brief Name) Percent SMI adults reporting satisfaction with housing				
Value				
IF Rate:	80.4%	78.9%	78.9%	
Numerator: Number of SMI adults reporting they are "very satisfied" and "somewhat satisfied" with their current housing arrangement	2798	2690	2690	
And				
Denominator: Number of SMI adults in sample.	3482	3411	3411	
7. Percent Seriously Mentally Ill Adults Who Have Had Contact With Criminal Justice System*				
(Brief Name) Percent SMI who have had contact with criminal justice system				
Value				
IF Rate:	4.7%	5.0%	5.0%	
Numerator: Number of SMI adults who have been arrested in past 12 months	164	170	170	
And				
Denominator: Number of SMI adults in sample.	3464	3393	3393	

* Only collect a subset of SMI from the OEI (RI's Outcome Evaluation Survey)

Action Plan for Criterion 1

Rhode Island will continue to provide a comprehensive array of services to both mentally ill and seriously mentally ill clients in the community. The State will continue to keep clients involved in their treatment plans and review aggregate client responses to satisfaction surveys with providers to ensure that they are aware of the areas in which they excel and those in which there are opportunities for improvement. The State will continue to enhance employment options for clients by funding programs like supported housing, increase the housing stock for mentally ill individuals through special grants like the threshold grant. Rhode Island attempts to reduce client contact with the criminal justice system through jail diversion programs like drug courts. Unfortunately, due to stresses on state budgets, the State does not expect to expand any services, simply maintaining service funding, rather than reducing it is the goal at this point.

Current Activities: Criterion 2

Goals, Targets and Action Plans for Criterion 2

The goal for reduction of hospitalization is:

Long-term care hospitalization should be provided only for those seriously mentally ill adults for whom community services have not yet been developed.

Rhode Island has a unique "State" hospital system in that long-term inpatient care is provided at the state operated general hospital and acute psychiatric care is provided at a private psychiatric hospital contracted by the state.

The number of State hospital psychiatric service admissions in FY 2004 was 836. Seventy-nine of those admissions were to long-term care at the state operated general hospital.

The total days of hospitalization in the State hospital psychiatric service in FY 2004 was 49,299 of which 43,365 were for patients at in long-term hospitalization at the state operated general hospital.

The primary goal of Criterion 2 is:

The number of seriously mentally ill adults in Rhode Island at any given time should be known.

This goal addresses the importance of generating a more rigorous understanding of both the total volume of seriously mentally ill adults and the extent to which they receive service.

The state also sets goals related to how it measures prevalence rates in Rhode Island. The goal of prevalence determination is:

To define the seriously mentally ill adult population in Rhode Island as those people meeting the NIMH definition of a community support client, to determine their incidence as a function of the total Rhode Island population and the crude death rate, to determine their prevalence by the Quadrant Method, and to consider that population to be a subset of the population of adults with serious mental illness as defined in the Federal Register.

The goal for provision of services to rural areas is the same as the goal for provision of services to all other areas in Rhode Island:

All seriously mentally ill adults in Rhode Island requiring community support services should receive them when necessary.

Criterion 2, Measure 1: Publicly Funded Service Access

Decade of Progress identified and measured the target population of seriously mentally ill people. It identified the locations in which they were to be found, the extent to which they were served, their functional level and various social, health, and economic characteristics. It established volume targets for their care in the public mental health system. Geographic Catchment area targets for the number of seriously mentally ill people to be served are included in annual MHRH-CMHC contracts for service.

The target number to be served in FY 2005 is the estimated number served in FY 2004. This target reflects the impact of continuing budget pressures. The specific objective for FY 2005 under this criterion is to serve at least 12,030 seriously mentally ill clients, distributed in accordance with Catchment area client volumes.

Catchment Area Providers	**Total Number of Adult Clients Served**	**Total Number of SMI Clients served**
Catchment Area #1: Northern R.I. CMHC	1030	801
Catchment Area #2: Community Counseling Center	1621	1291
Catchment Area #3: The Providence Center	7499	3833
Catchment Area #4: Mental Health Services	1550	1607
Catchment Area #5: Kent Center	1684	1276
Catchment Area #6: South Shore CMHC	1891	1130
Catchment Area #7: East Bay CMHC	2206	1198
Catchment Area #8: Newport County CMHC	943	667
Total within catchment system	*18424*	*11803*
Other Providers		
Riverwood CMHC	130	121
Fellowship Health Resources	112	102
North American Family Institute	7	4
Total served by other providers	*249*	*227*
Total Clients Served	**18627**	**12030**

Criterion 2, Measure 2: Prevalence determination

Goal: To estimate the penetration rate of mental health services in Rhode Island to the seriously mentally ill, based on CMHS prevalence estimates.

Population: Adults diagnosed with serious mental illness.

Criterion: Prevalence and treated prevalence of mental illness.

Brief Name: Prevalence determination.

Indicator: Percentage of adults in Rhode Island with serious mental illness receiving services in the publicly funded system.

Measure: **Numerator:** Number of adults with serious mental illness served by the publicly funded system.

Denominator: Number of adults with serious mental illness as determined by CMHS

Sources of Information: MIS reporting system

Special Issues: None

Significance: This measure is a reflection of the effectiveness of the publicly funded mental health system's outreach.

Criterion 2, Measure 3: Utilization Rate

Goal: All seriously mentally ill adults in Rhode Island requiring community support services should receive them when necessary.

Population: Adults diagnosed with serious mental illness.

Criterion: Prevalence and treated prevalence of mental illness.

Brief Name: Utilization Rate

Indicator: Rate of mental health service utilization per 100,000 population.

Measure: **Numerator:** Total number of adult clients with serious mental illness served in the publicly funded system.

Denominator: Total adult population

Sources of Information: MIS reporting system

Special Issues: No special issues

Significance: The number of adult clients served in the past three years has increased steadily, despite a great deal of stress to the system due to budget crises within the state and the community economy as a whole.

Criterion 2 Mental Health Performance Indicator Statistics

STATE MENTAL HEALTH PLAN FY 2005

PERFORMANCE INDICATORS

Population: SMI Adult or SED Children (Circle one)

Criterion II: Prevalence and Treated Prevalence of Mental Illness

(Please start a new page for each of the criteria.)

Performance Measures:	FY 2003	FY 2004	FY 2005	%
	Actual	Projected	Objective	Attain
2. Prevalence Determination				
(Brief Name) Percentage of Adults with SMI Served				
Value	25.3%	26.8%	26.8%	
IF Rate:				
Numerator: Number of adults with SMI served	11,361	12,030	12,030	
Denominator: Number of Adults with SMI	44,846	44,846	44,846	
3. Utilization Rate				
(Brief Name) Rate of Utilization per 100,000 Population				
Value	1,378	1,453	1,453	
IF Rate:				
Numerator: Number of Adults with SMI served	11,361	12,030	12,030	
Denominator: Total Adult Population of Rhode Island	824,229	828,226	828,226	

Action Plan for Criterion 2

Rhode Island will continue to provide services to clients and measure penetration rates to help plan the distribution of existing services. Unfortunately, due to stresses on state budgets, the State does not expect to expand any services, simply maintaining service funding, rather than reducing it is the goal at this point.

Current Activities: Criterion 4

The State is currently involved in serving the Homeless through PATH Grant activities with State matching funds and by investing in housing solutions for the mentally ill. In terms of rural issues, the state is unique in its small size and has dealt with the geographic dispersion of services by organizing

the state into regional catchment areas. For more details on the State's current Activities: Criterion 4 see "State's Strengths and Weaknesses Related to Criterion 4," page 38.

Goals, Targets and Action Plans for Criterion 4

Two goals have been identified for criterion 3, the first is:

To serve the needs of the homeless in Rhode Island

The second goal within the realm of Criterion 3 is:

To ensure that services are available in all parts of Rhode Island

Criterion 4 Mental Health Performance Indicator Descriptions

Two performance indicators are used to measure the extent to which outreach and services to the homeless goals are achieved:

1. Number of homeless mentally ill adults served.

2. Percentage of mentally ill adult clients served who are homeless

Owing to the limited significance of this issue in Rhode Island, no performance indicator is used to measure the extent to which service provision to rural areas is achieved.

Criterion 4, Measure 1: Homeless Adults Served

Goal: To capture homelessness among mentally ill adults in Rhode Island and to provide appropriate access to the mental health treatment system for them.

Population: Adults diagnosed with mental illness.

Criterion: Targeted Services to Homeless and Rural Populations.

Brief Name: Services for homeless adults.

Indicator: Homeless mentally ill adults served.

Measure: Number of homeless mentally ill adults served.

Sources of Information: MIS Reporting System

Special Issues: None

Significance: This measure is a reflection of the extent to which the mental health system extends its services to homeless people in need of those services.

Criterion 4, Measure 2: Homeless Adults in SMI Population Served.

Goal: To capture homelessness among seriously mentally ill adults in Rhode Island and to provide appropriate access to the mental health treatment system for them.

Population: Adults diagnosed with serious mental illness.

Criterion: Targeted Services to Homeless and Rural Populations.

Brief Name: Homeless Adults in SMI Population Served.

Indicator: Percentage of seriously mentally ill adult clients who are homeless.

Measure: **Numerator:** The number of seriously mentally ill adult clients who are homeless.

Denominator: The total number of seriously mentally ill adult clients served.

Sources of Information: MIS Reporting System

Special Issues: None

Significance: This measure is a reflection of the effectiveness of outreach efforts in identifying and servicing mentally ill people who are homeless.

Criterion 4 Mental Health Performance Indicator Statistics

STATE MENTAL HEALTH PLAN FY 2005

PERFORMANCE INDICATORS

Population: SMI Adult or SED Children (circle one)

Criterion III: Targeted Services to Homeless and Rural Populations

(Please start a new page for each of the criteria.)

Performance Measures:	FY 2003	FY 2004	FY 2005	%
	Actual	Projected	Objective	Attain
1. Services for Homeless Adults				
(Brief Name) Number of Homeless Mentally Ill People Served				
Value:	1.8%	2.1%	2.1%	
IF Rate:				
Numerator	348	399	399	
AND				
Denominator	19,030	18,627	18,627	
2. Homeless Adults in SMI Population Served				
(Brief Name) Percentage of SMI Clients Who are Homeless				
Value:	1.8%	2.3%	2.3%	
IF Rate:				
Numerator: Number of SMI Clients Who are Homeless	210	274	274	
AND				
Denominator: Total Number of SMI Clients Served	11,361	12,030	12,030	

Action Plan for Criterion 4

Rhode Island will continue to provide services to homeless clients and those living throughout the state. Unfortunately, due to stresses on state budgets, the State does not expect to expand any services, simply maintaining service funding, rather than reducing it is the goal at this point.

Current Activities: Criterion 5

The State provides leadership through funding, licensing, planning, and monitoring programs. The State also funds the training of direct service staff. In addition, the state serves as a clearinghouse of data information for both providers and consumers to help them make decisions on what programs they should advance or advocate for and what changes they would like to see in the system. For more

detailed information regarding the State's Activities: Criterion 5, refer to "State's Strengths and Weaknesses Related to Criterion 5," page 41.

Goals, Targets and Action Plans for Criterion 5

One of the goals for criterion 5, management systems is:

To maintain a trained professional workforce

A variety of training activities are conducted by individual CMHCs to improve skills of emergency health service providers in delivering mental health services.

- Consults with hospital emergency room staff providing training and triage.
- On-site training for emergency medical technicians (EMT's).
- CMHC emergency service rotation to family practice/internal medical residents.
- Educational programs for area practicing physicians.
- Educational programs with hospital departments of psychiatry.
- Training of police departments.
- CMHC staffing of major trauma-center hospital emergency department.
- Disaster response training for all state departments and networks of local providers including community mental health centers.

A statewide program to train and certify community support professionals (case managers) has been in operation since 1987. As of FY 2004, it has certified 1128 community support professionals, and trained 1664.

Another goal of criterion 5 is:

To distribute funds appropriately throughout the system of care in Rhode Island

Criterion 5 Mental Health Performance Indicator Descriptions

Criterion 5, Measure 1: Mental health Expenditures

PROJECTED FY 2004 EXPENDITURES

BLOCK GRANT AND RELATED FUNDS

CRITERION	BLOCK	STATE	STATE	OTHER	TOTAL

	GRANT	COMMUNITY	ADMIN.	FEDERAL	
1. Comprehensive Systems	1,288,087	39,652,812	654,689	35,749,169	77,344,757
2. Prevalence	10,000				10,000
3. Targeted Services	10,000			300,000	310,000
4. Management Systems	20,000			199,120	219,120
5. Children's Services	150,354	22,069,630	907,000	24,714,000	47,840,984
TOTAL	1,478,441	61,722,442	1,561,689	60,962,289	125,724,861

Criterion 5, Measure 2: Training

Goal: Public mental health system professionals should be capable of providing state-of-the-art community-based services to adults with serious mental illness.

Population: Adults diagnosed with serious mental illness.

Criterion: Management systems.

Brief Name: Community support professionals (case management) training.

Indicator: Number of community support professionals (case managers) trained/certified.

Measure: Number of community support professionals (case managers) trained/certified.

Sources of Information: Rhode Island Council of Community Mental Health Organizations Data

Special Issues: None

Significance: Case managers are the staff most directly involved with clients on a day-to-day basis. Their training is crucial.

Criterion 5, Measure 3: Per Person Expenditures

Goal: The funding of services for seriously mentally ill adults should be sufficient to assure provision of those services necessary to improve or maintain client functional level status.

Population: Adults diagnosed with serious mental illness.

Criterion: Management Systems.

Brief Name: Per person expenditures.

Indicator: Community mental health expenditures per person served.

Measure: **Numerator**: Community funds expended on services for seriously mentally ill clients.
Denominator: Number of seriously mentally ill clients served.

Sources of Information: MIS reporting system

Special Issues: None

Significance: Expenditures per person served is a rough measure of commitment to provide necessary services. It is more meaningful when used in comparison to similar figures from other jurisdictions.

Criterion 5 Mental Health Performance Indicator Statistics

STATE MENTAL HEALTH PLAN FY 2005

PERFORMANCE INDICATORS

Population: SMI Adult SED Children (circle one)

Criterion IV: Management Systems

(Please start a new page for each of the criteria.)

Performance Measures:	FY 2003 Actual	FY 2004 Projected	FY 2005 Objective	% Attained
2. Case Management Training				
(Brief Name) Number of Community Support Professionals (Case Managers) Trained/Certified				
Value:	106/44	132/96	100/70	
IF Rate:				
Numerator				
and				
Denominator				
3. Mental Health Expenditures				
(Brief Name) Community Mental Health Expenditures per Person Served				
Value:	$5,411	$5,131	$4,929	
IF Rate:				
Numerator: Funds Expended on Community Services to SMI Clients ($)	$61,476,594	$61,722,442	$59,299,652	
And				
Denominator: Number of SMI Clients Served	11,361	12,030	12,030	

Action Plan for Criterion 5

Rhode Island will continue to provide leadership through funding, licensing, planning, and monitoring programs. The State also funds the training of direct service staff. In addition, the state serves as a clearinghouse of data information for both providers and consumers to help them make decisions on what programs they should advance or advocate for and what changes they would like to see in the system. Unfortunately, due to stresses on state budgets, the State does not expect to expand any services, simply maintaining service funding, rather than reducing it is the goal at this point.

b) Children's Plan

1) Current Activities

DCYF has recently implemented a new policy/procedure protocol for the review of all children/youth who are in the care and custody of the Department of Children, Youth and Families (DCYF). This new protocol more clearly details the responsibilities and the relationships between the Care Management Teams (**CMTs**) and Resource Management Team (**RMT**) at the DCYF. The functions of the DCYF Care Management Teams and the Resource Management Team. Please refer to Section II, b for a more detailed description of the children's mental health system.

Goals, Targets and Action Plans

Criterion 1: Comprehensive Community-based Mental Health Service Systems

Goal: Establish and implement a comprehensive community-based mental health service system.

The plan describes health and mental health service, rehabilitation services, employment services, substance abuse services, housing services, educational services, medical and dental care, and other support services to be provided to such individuals with federal, state, and local public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities, including services to be provided by local school systems under the individuals with disabilities.

Background: The Rhode Island Children's Behavioral Health System of Care

For more than a decade, Rhode Island has provided services to children with serious emotional and behavioral disorders and their families within a statewide network of eight local coordinating councils, known as LCCs, and organized by catchment areas that are managed through the Rhode Island Department of Children, Youth, and Families (DCYF). These LCCs are part of the overall statewide system of care for children's behavioral health that consists of local networks of providers, families, advocates, and representatives from community organizations that work together to develop coordinated services for children and youth with serious challenging behaviors. In Rhode Island, systems of care for children and families emphasize: 1) integrated services across providers; 2) services that are child-centered and strength-based; 3) family-focused service planning; 4) culturally competent services; 5) services that are flexible, least restrictive, and close to home; 6) the integration of natural community supports into the provision of services; and 7) community ownership through the active involvement of key community stakeholders, such as family members, providers, funders, and community representatives. Behavioral health services for children and youth are organized through a central office at DCYF with contracts to local mental health centers and LCCs to provide 24-hour emergency services, screening for inpatient psychiatric hospitalization, and a vast array of

traditional and non-traditional therapeutic services for the child and family. A primary goal of each LCC is to prevent out-of-home placement and out-of-community placements.

The Rhode Island behavioral health system of care for children and youth was formally established in 1990, when Rhode Island received its initial funding to implement the Child and Adolescent Service System Program, or CASSP, from the National Institute of Mental Health. The CASSP grant established the LCCs and provided support to coordinate and evaluate the system of care. The initial focus of the CASSP initiative was to develop effective interventions for children at risk for out-of-home placement, and this emphasis continues to the present day. LCCs meet at least monthly and are responsible for assessing the service needs of families, identifying system barriers that impede effective service delivery, reaching out to families and local community organizations, advocating for system changes, and managing a multi-agency case review process through community planning teams.

In 1994, the CASSP structure was expanded through an additional federal service development grant to the Rhode Island DCYF from the Center for Mental Health Services (CMHS). This second grant ensured that the CASSP philosophy and orientation to service delivery was sustained statewide. In that same year, Rhode Island was successful in obtaining another major new grant from CMHS that enabled the state to enhance existing services within each of the LCCs. Known as Project REACH Rhode Island, this initiative consisted of a five-year, $15.8 million grant from CMHS that was part of the Comprehensive Community Mental Health Services for Children and their Families Program. The overall goal of Project REACH was to develop and implement non-residential and community-based integrated services statewide, particularly for children at risk for out-of-home placement. The five specific project goals of REACH were to: 1) augment existing services; 2) develop new services when indicated; 3) monitor and evaluate the system of care; 4) assure diverse participation; and, 5) strengthen the existing interagency framework.

A study conducted by the Yale Consultation Center revealed that changes in service access during three historical phases of implementation of Rhode Island's behavioral health system of care for children and youth are examined in the context of the study hypotheses described earlier. The two indicators of access used – services received as a proportion of those recommended and barriers per service recommended – complement prevailing definitions of access based primarily on individual service utilization. In addition, the collection of statewide data offers a unique opportunity to examine the system-level impact on service access that results from a well-funded system of care service development initiative. Three distinct phases in the development of the system of care are examined: 1) the period after initial receipt of CASSP funding to establish the system of care; 2) the period at the midpoint of service system development following the allocation of CASSP continuation funding and REACH service enhancement funding to expand the system of care; and 3) system-wide adoption of the CASSP philosophy and full implementation of system of care service enhancements. Tracking access across these three phases begins to establish empirical benchmarks for understanding access in the context of a developing system of care.

The vast majority of children referred (75.7%) demonstrated moderate levels of functioning and symptomatology (scores of 41 - 60) as assessed by the Children's Global Assessment Scale, or CGAS (Schaffer et al., 1983), with the remaining about equally split between children exhibiting lower (14.0%) or higher (10.3%) levels of functioning. Children scoring between 41 - 60 on the CGAS ranged in their functioning from "Moderate degree of interference in functioning in most social areas

or severe impairment of functioning in one area" (41-50) to "Variable functioning with sporadic difficulties or symptoms in several areas but not all social areas" (51-60). Children and youth in these two areas are considered to be at-risk of out-of-home placement. Finally, referrals to the system of care came primarily from mental health agencies (41.2%), schools (19.2%), and parents/friends/self (17.9%), with the remaining 21.7 percent coming from the DCYF, the judiciary, social service agencies, physicians, and other sources.

Procedures: All children and youth who participated in the study were referred to the multi-agency team within one of eight LCCs. Each LCC has at least one multi-agency team that reviews cases to assist the family in identifying and coordinating needed services within the local system of care, and if necessary, from other local systems of care statewide. LCCs meet monthly and are responsible for assessing the service needs of families, identifying system barriers that impede effective service delivery, providing outreach to families and local community organizations, advocating for system changes, and managing the multi-agency case reviews. Much of this work is done by Family Service Coordinators, who are parents/caregivers employed by the system of care within each LCC. Services that are available and initiated through the LCC case review process include: therapeutic recreation, respite, in-home behavior therapy and parent training, day treatment, therapeutic foster care, and wrap-around services (which are non-traditional supports for children, youth, and families). The LCCs do not provide direct clinical services; rather, these and other direct non-clinical services are provided by contracted community agencies, many of whom are participants in the LCCs. (Source: Yale Consultation Center).

Considered in combination, theses cost-outcome findings involving children's behavior problems, global functioning, school attendance, and school performance suggest that, on a state-wide basis, resources are being allocated appropriately in accordance with children's need for services in the least restrictive setting.

Evidenced-Based Practices:

There are five Promising Practices in RI which this report will describe as approaching the realm of Evidence Based Practices. These five are:

1. RIte Care

3. Project Hope

2. CASSP

4. Children's Intensive Services (CIS)

5. Multisystemic Treatment (MST)

Evidenced-Based Practice 1, RIte Care

A new report published this May 2004 by the Center for Health Care Strategies (CHCS) highlights four states' Medicaid Managed Care Programs, including Rhode Island's RIte Care Program The report focuses on four states that have excelled in producing reports, defining performance measures

and evaluating programs. RIte Care's performance-based contracting and, in particular, its use of information continually improves is highlighted.

Some examples of the RIte Care Program's evaluation operations in the report include:

1. Use of encounter data;

2. Use of consumer focus groups in program design and evaluation;

3. Collaboration with Brown University health researches and the RI Department of Health in the creation of the Medicaid Research and evaluation Project; and

4. Use of consumer advocates' input to improve programs

Evidenced-Based Practice 2 ,CASSP

In the systems of Care, Promising Practices in Children's Mental Health, published by SAMHSA, page 19, Rhode Island's use of Family Services Coordinators as a central part of the CASSP system of Care was cited as a Promising Practice. While not quite classified as Evidenced-Based, the state is in the process of collating longitudinal data , with the assistance of the Yale Consultation Center, with the objective of elevating this CASSP System of Care to the status of Evidence Based.

Evidenced Based -Practice 3, Project HOPE

On June 10 2004, the National Center of Mental Health and Juvenile Justice sent a letter of support to the DCYF regarding its grant application-Project New Freedom. Citing Project HOPE, the letter of support went on to state: *"We have assisted with the dissemination of this model through technical assistance with other communities and through a teleconference we organized for the Office of Juvenile and Delinquency Prevention (OJJDP). Further, we intend to highlight Project HOPE as one of the "best practice" sites for a national project we are doing for OJJDP to develop a comprehensive model for how to best provide mental health and substance abuse services to youth in contact with the juvenile justice system".*

In addition, the Department is moving towards an additional Best Practice which should mature into an Evidenced Based Practice as it matures and outcomes are evaluated. This is the "new" Children's Intensive Service program. This clinically intensive, community based, family focused service has been transformed to a Medicaid Certified Program. All nine vendors have been fully operational since May 1, 2004.

Evidenced Based Practice 4, Children's Intensive Service (CIS)

The "new" CIS program that became fully operational in May of 2004, is a Medicaid Certified, community and family based clinical intervention program. This is a state wide program with features such as: family choice; levels of intervention from psychiatrists through Family Service Coordinators; a strong UR/QA component performed by a unit of reviewers who are at 'arms length' from the Medicaid agency; clear out come measures; emphasis on family satisfaction

survey's and program input; the use of widely recognized-valid and reliable clinical measurement tools; as well as clinical quality consistence among each of the current nine Certified vendors.

Evidenced Based -Practice 5, MULTISYSTEMIC TREATMENT

The DCYF is in the process of issuing a Letter of Interest to vendors in the state to establish and operate support services grounded in evidenced-based or outcome based practices within each of the four regional areas of DCYF. Mutisy stemic Treatment is an empirically proven promising practice to treat youth who present with intense clinical needs. The comprehensive team approach MST uses serves youth both individually and within the context of their family system. The successful applicant(s) will be responsible for designing and implementing, individualized plans for the referred youths and their families. All referrals would come from one of the four regional DCYF offices, which cover the whole state. The intent of this program is to maintain highly challenging children and youth in their own homes, or a Foster Home, and to return other highly challenging children to their own homes or to a Foster Home if necessary. It is expected the success of this approach will assist in transition from and the use of high end residential beds, hospital bed days and help reduce utilization of the RI Training School for Youth – RI's juvenile correctional site. Components of the program will include: a Continuous Quality Improvement process; clear outcome measures; cultural competency; intense and brief (for the most part 2-3 in duration) multi-focused services geared to the specific needs and strengths of the particular child; and a strong family centered/community based modality.

Criterion 1, Goal and Indicator 2: Consultation

Maintain the Department's collaboration with the Governor's Council on Mental Health. This includes staffing appropriate working subcommittees as formulated.

At the present time the department will maintain its co-staffing responsibility for three active sub-committees of the Council working with the Department of Mental Health, Retardation and Hospitals.

The department continues to work with the Yale Consultation Center to evaluate CASSP and the new Children's Intensive Service (CIS) program.

The department continues its relationship with the Parent Support Network- which staffs a DCYF Youth Parent Advisory Council.

In addition, the department will continue its representation on the full Council. This membership will include the Assistant Director of Children's Behavioral Health, a Community Services Coordinator and other DCYF staff as appropriate.

Criterion 1, Goal and Indicator 3: Collaboration

The Department will continue to work collaboratively with the Department of Education to more effectively plan and fund needed residential placements for the youth of R.I.

A new level of this planning has already started as a result of DCYF being an active member of the CEDARR Inter-Departmental Team. This team is composed of the Department of Education, the Department of Health and the Department of Human Services. It has a strong system advisory role with the development of the CEDARR initiative in the state of R I. CEDARRs are a one stop family service center for all Medicaid eligible families in the state. CEDARR Family Centers can help children with special health care needs and their families with their need for information, professional assessment, specialty clinical evaluation, care planning, coordination of services, and ongoing referral and support.

Criterion 1, Goal and Indicator 4: Out-of-State Placement

To reduce the numbers of R.I. youth in out of state Purchase of Service (POS) residential programs.

It is planned that the number of youth placed in out of state Purchas e of Service (POS) treatment slots will be reduced from last year's level. For example at the end of June 2004, there were 106 youth in POS out of state. Out -of-State Placements

The Department has been able to slow the rise of the out of state purchase of service (POS) residential placements. There were **106** youth in POS in FY 04**; 97** in POS in FY 03; **132** youth in POS in FY02, **196** youth in POS in FY 01, **149** youth in POS in FY 00, **145** youth in POS in FY99 and **120** youth in POS in FY 98. The FY 04 figure represents almost a 20% reduction in out of state POS since 1998.

The goal for FY 2005 for this category of residential treatment is **42**

At the same time the number of in-state residential placements (part of the POS grouping) increased from **108** in FY 99 to **109** in FY 00, then decreased to **104** in FY 01 and was increased to **135** in FY02 and increased to **192** in FY 03 and increased to **254** in FY 04. Additional instate residential treatment options came online in FY 04 which account for this shift. These include group homes, an expansion of the NETWORK, and increased capacity in Foster Homes.

Utilization and Review Contract

The Department, through an RFP, has initiated a Utilization and Review Contract that was fully operational in September 2001.

The UR staff has been working collaboratively with the Department's social workers, the Care Management Teams (CMTs), appropriate administrative staff and outside agencies to ensure proper transitional placements-whether they be more intensive residential or community based with the youth returned to home.

Additional new authority was given to the UR group which will now allow the contractors to make recommendations to the four DCYF Regional Directors and other levels of administration regarding the following:

- Changes in Placement from In- State or Out - of- State Purchase of Service (POS) residential to home:

- Changes in Placement from In-State or Out-of-State POS Residential to Contracted Therapeutic Foster Care:

- Changes in Placement from In-State or POS Residential to DCYF Managed foster Care; and

- Changes in Placement from In-State or Out-of-State POS Residential to In-State Contracted Residential

Any or all of the above Placement change recommendations may include recommendations for the utilization of customized wraparound services depending on the needs of the youth and family.

Criterion 1, Goal and Indicator 5: Substance Abuse

The Department will continue to expand the array of substance abuse services available to children, youth and families involved with the Department.

The Departments full time Substance Coordinator continues to provide clinical oversight to the 24-bed residential treatment program within the R I. Training School for Youth (RITSY), the state's juvenile corrections facility.

The Department has applied for a federal grant to fund additional services for services for youth leaving the RI Training School for Youth who are dually diagnosed. The National Center for Mental Health and Juvenile (NCMJJ) states that this grant, **Project New Freedom**, "…will benefit from a nationally recognized model of providing culturally component, youth and family focused services to transitioning youth." (June 2004 letter from Mr. Joseph Cocozza of NCMHJJ).

The Department will continue to work, along with the Department of Mental Health Retardation and Hospitals (MHRH) to more fully integrate substance abuse treatment services and behavioral health services. The Department of Substance Abuse for the state is housed within MHRH. It is anticipated that by the end of FY 2005 a more formalized working relationship will exist between the Departments of Human Services, Health, Elderly Affairs MHRH and DCYF. The Governor is moving rapidly along on the creation of a Secretariat position in the Cabinet. The primary responsibility of this new position would be the coordination of all aspects of programming and funding for the major human services departments in state government. This position will lead to a more coordinated substance treatment and prevention effort within the state for both children and adults. The Department's Substance Abuse Coordinator is a regular, active attendee of the Governor's Council on Behavioral Health. This activity is designed to provide additional family/child focus to the prevention programs being developed and funded by MHRH. This activity may affect the way in which the Mental Health Block Grant and the various substance abuse grants administered through MHRH are developed and implemented.

Criterion 1, Goal and Indicator 6: Scope and Availability of Services

Scope and availability of services that address the criterion for a comprehensive community-based mental health service systems

This section will provide a description of available services, treatment options, and available resources (including federal, state and local public services and resources) to be provided to SED children and youth.

Publicly funded children and adolescents entering the service system from Child Welfare, Juvenile Justice or Children's Behavioral Health have access to an array of mental health services. These range from outpatient counseling available at each of the state's Community Mental Health Centers (CMHCS) through inpatient hospitalization. Refer to Section II, b, iii: "Children Services" for a complete program description of these services.

Criterion 1, Goal and Indicator 7: Service Maintenance and Development

In FY 2005 the Department will continue to support the existing array of mental health services. In addition the Department will develop and implement three additional mental health programs for youth in the state.

In FY 2005, the Department will be in the last year of a federally funded program designed to provide transition services for youth on probation and leaving the R.I. Training School for Youth. This project is called Project Hope. The department is in the process of sustainability planning to convert this federally funded program to all state dollars in the second half FY 05.

The Department will fully implement a third Residential Counseling Center for youth ages 12-18.

The Department will develop and implement a Residential Counseling Center for latency aged girls.

Criterion 1, Goal and Indicator 8: Residential Diversion

In FY '2005, 90 cases will be diverted from residential care by CASSP integrated community-based services including: mental health, early intervention, child welfare, social, educational, juvenile justice, recreational, and vocational services. Public and private resources will be utilized in developing individualized case plans.

The Community Planning Team review process will continue to be evaluated using an instrument similar to that which was used in the statewide evaluation project. Families now will have a choice of having a case review using the existing Core Team format or the new Family Conferencing format.

Criterion 1, Goal and Indicator 9a: Reduction of Hospitalization

In FY 2005 the CIS Program will change form a contracted program , to a Certified program..

The CIS Program is a high-end community based therapeutic hospital diversion program. Its performance is measured monthly, each quarter and at the end of the program year. The Department tracks bed day utilization rates on a bi-weekly basis. The Department is expecting to reduce the use of its psychiatric bed days compared to FY 2002. This amounted to 279 admissions in FY 2001 and 261 in FY 02. At the present time a vast majority of publicly funded youth have been enrolled in RI's managed health care system-RIte Care. In FY 02 this figure was 601 As a consequence, DCYF has a decreasing role to play regarding psychiatric hospitalizations of children and youth. A majority of the utilization review, discharge planning and approvals go through the managed care plans now. This is an evolving process, and can be reported on in more detail in the next Block Grant application. In addition, by the end of FY 05 all Children with Special Health Care Needs will be enrolled in Rhode Islands managed health care system-RIte Care. This will further reduce the Departments role in admissions and UR activity across the spectrum of Behavioral Health Services-including hospitalizations.

Some preliminary demographic data from the "new" CIS:

The Consultation Center at Yale University School of Medicine is conducting a statewide evaluation of the implementation of Children's Intensive Services (CIS) - a 6-month acute hospital diversion program that provides community-based services for youth (ages 3-18) at risk for hospitalization or out-of-home placement. The evaluation examines monthly service utilization patterns for CIS clients served statewide through all certified CIS provider agencies. This evaluation report provides information on demographic and clinical characteristics of children admitted to CIS during the month, information on the total population of children served during the month, as well as information on the amount and types of services provided to children. In addition, information regarding the status of children discharged from CIS and information on performance indicators being tracked by CIS providers is included in this report. An appendix summarizes data broken down by CIS provider.

A total of five agencies provided information for children served by CIS for the month of May. These agencies included the Community Counseling Center of Pawtucket; Family Services of Rhode Island; Mental Health Services of Cranston, Johnston, and NW RI (Metro West); NRI Community Services, Inc.; and South Shore Community Mental Health Center. A total of 250 children were admitted to CIS programs during the month of May, and a total of 527 children were served by reporting providers during the month.

PROFILE OF CLIENTS (NEW ADMISSIONS)

Demographic Characteristics: Approximately 60% of children admitted to CIS, statewide, were males, and the mean average age of children receiving CIS services was approximately 12.2 years old at the time of admission. Figure 1 provides information on the age breakdown of children.

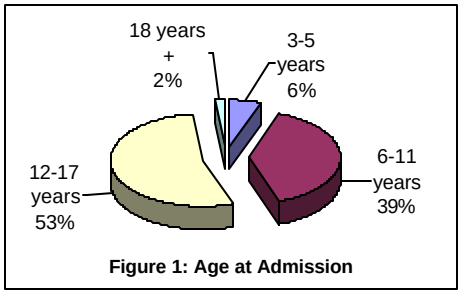


Figure 1: Age at Admission

Information on race and ethnicity of children at the time of admission is indicated in Figure 2. Nearly half of children admitted to CIS in May were White, and one-quarter of admissions were identified as Hispanic. Medicaid was indicated as the primary payment source for 83% of children, and as a secondary payment source for 8% of children.

Residential information at the time of admission was missing for approximately 2/3 of children (60%); 34% of children were residing in a private residence, 3% in subsidized housing, and 2% in a group home/residential facility or foster home.

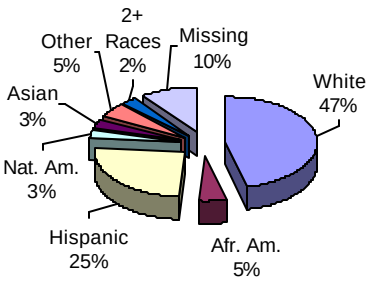


Figure 2: Race/Ethnicity

Social service agencies provided approximately 20% of referrals to CIS (see Figure 3), though most referrals (30%) came from "other" sources and 10% were unknown or missing. Approximately 8% of all referrals for new admissions came from inpatient psychiatric facilities. Ten percent (10%) involved a self-referral or that of a family member or friend, and an additional 10% came from the educational system.

Clinical Information: Among the 250 new admissions in May, none (**0%**) were admitted at Level 1 (Crisis Management/Stabilization), **9%** were admitted at Level 2 (Standard Care), **83%** were admitted at Level 3 (Intermediate Care), and **8%** were admitted at Level 4 (Maintenance). Figure 4 provides information on the range of Modified Children's Global Assessment Scale (M-CGAS) scores for children by CIS Level at the time of admission. The mean M-CGAS score for all new admissions was **45.0**. As can be seen in the figure, M-CGAS scores correspond well with CIS Level – the red box represents 50% of the M-CGAS scores for each level, and the line through the box represents the median M-CGAS score for each level. The "whiskers" coming off of each box represent the range of scores falling within a normal distribution, while circles and asterisks represent individual outliers and extreme cases falling further from the normal range of scores. As can be seen in the figure, there is some variability and overlap in M-CGAS scores across CIS Levels at admission.

Figure 3: Referral Source (New Admissions)

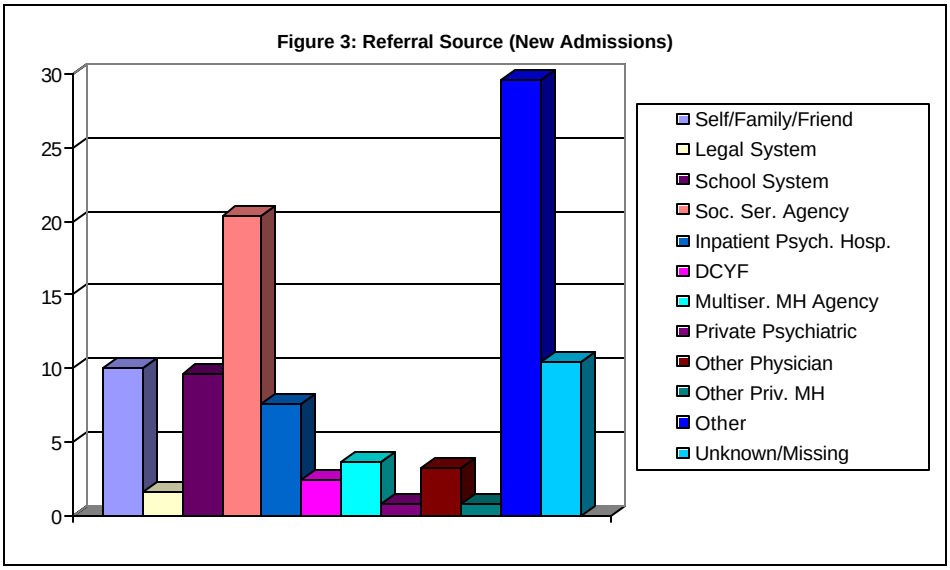
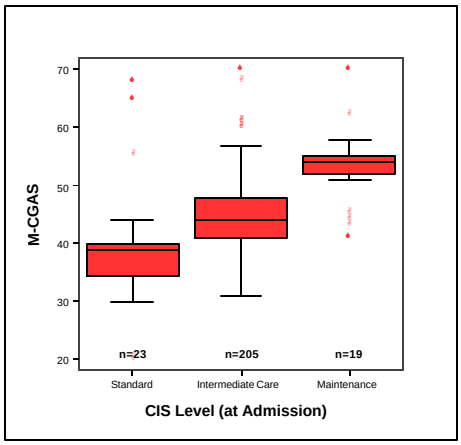
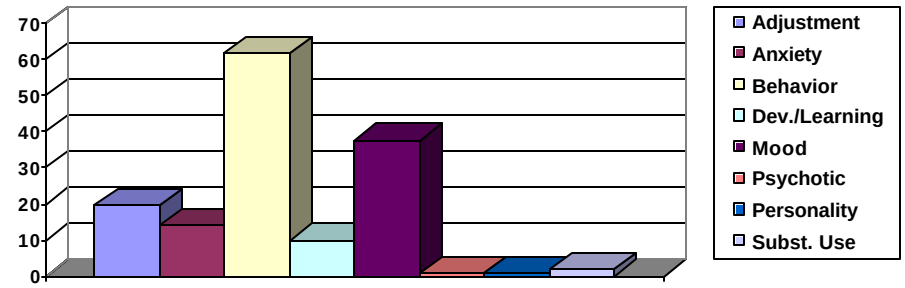


Figure 4: M-CGAS by CIS Level



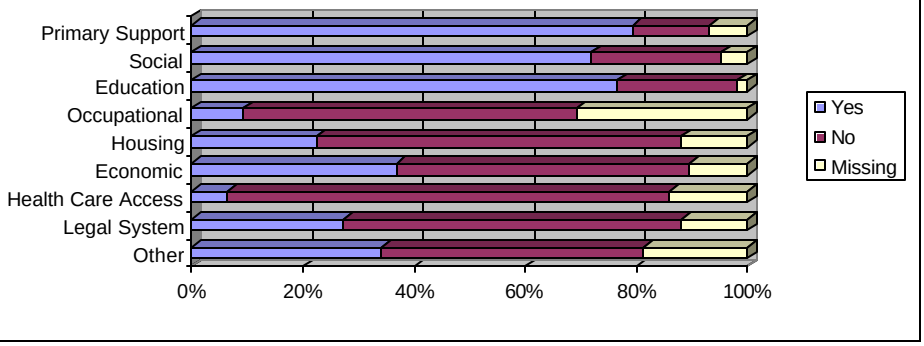
Diagnostic information was provided for new admissions – agencies were able to provide up to three diagnoses for Axis I and two diagnoses for Axis II. This diagnostic data was categorized to provide a breakdown of the types of cases being admitted to CIS (see Figure 5). Nearly 2/3 of cases (**62%**) were admitted with a diagnosis of behavioral disorder (e.g., conduct disorder, oppositional defiant disorder, ADHD); approximately **40%** involved diagnosis of a mood disorder (e.g., Major Depression, Bipolar Disorder); Adjustment disorders (**20%**) and anxiety disorders (**14%**) were also reported for a significant portion of children.

Figure 5: Diagnoses at Admission



In addition, agencies provided information on problems present in a number of domains within the child's life as captured in Axis IV of the DSM -IV (see Figure 6). Over three-fourths of children exhibited problems in their primary support group, social environment, and educational settings, and a substantial number of children faced economic or housing problems, or involvement with the legal system.

Figure 6: Life Domain Problems (Axis IV) at Admission



Additional programming steps to be taken by the DCYF to reduce hospital bed day utilization will include:

- More aggressive hospital care management: the department will continue its work with Child by Child 11 (intensive individualized service planning for children/youth in the hospital).
- Accelerate the redesign of service delivery and the system of Care: over the next several months the department continue to redesign it's system of care to make it more family centered and

community based to ensure that he department manages more effectively all out of home placements and improve the integration of thee services with home and community based non residential/non hospital services.

In addition, the Dep artment will monitor, on a state-wide basis, the readmission rate at the psychiatric hospitals within 30 days **(44 in FY 02 and 41 in FY 03)** ; readmitted within 180 days of discharge **(76 in FY 02 and 67 in FY 03**). Both these indicators are being re-designed to capture the complete universe of children and youth, not just those publicly funded. For **FY 04 there were 10 readmissions after 30 days and 38 after 180 days**.

It should be noted that these are figures only for Medicaid only publicly funded children and youth. The department is in the process of working with the Department of Human Services and its billing agent to develop a report which will capture this data for all publicly funded kids/youth. RI has a well development managed heath care system for Medicaid eligible families, RIte Care, which pays for many psychiatric hospital bed days as well. In the next Block Grant reporting cycle Rhode Island will be able to compile a complete profile of all children/youth who access the two psychiatric hospitals in RI. This report will include:

- Age, ethnicity, race, gender
- Length of stay
- Readmissions at 30 and 180 days

The unduplicated count for Medicaid only youth in the psychiatric hospitals for the past two fiscal years is as follows:

- 7/1/02-6/30/03= 149
- 7/1/03-6/30/04= 140

Supplementary Demographics for the Department of Children, Youth and Families: as of 6/30/04, Children/Youth in Care or Custody:

Gender	Male	4596
	Female	3517
Total		**8128**
	All Clients	Hispanic Clients
Race		(subset of "All Clients")
Am Ind/Alaskan	104	14
Asian	153	0
Black	1620	181
Nat Haw/Pac Islander	5	2
White	5098	810
Unknown	910	410
Multiracial	238	34
TOTAL	8128	1451

Criterion 1, Goal and Indicator 9b: Reduction of Hospitalization

The Department will expand the array of home based and community bed capacity, in an attempt to reduce the reliance on the more long term use of psychiatric hospitalizations.

The Department will add 16 hospital step down beds and 50 therapeutic Foster Homes to the array of Home Based Care and Services in FY2005. This is expected to lead to the reduction of the need for 10 out of sate placements, reduce the need for night-to-night placements as well as to reduce hospital admissions.

The Department has a goal for FY 05 of the reduction in the use of hospital bed days from the May 04 figure of 45 a month, down to 20 a month by July of 2004 and continuing trough June 2005.

Criterion 1, Goal and Indicator 10: Care Management Services

The plan requires the provision of care management services to each such individual in the state who receives substantial amounts of public funds of services.

In FY '2005, all of the 8 LCCs will have state funds available to allow for continued operations after the expiration of the federally funded Project REACH grant. All new cases, as well the pre-existing cases-reviewed through the CASSP Case Review process will have case managers.

The Department continues to have access to state funds that support community-based programs formerly funded through Federal Grant-Project REACH R.I. In addition, the new federal grant - Project HOPE - which began in FY 2000, means an additional stream of funds that will be utilized by the LCCs in the amount of about $2 million for FY 2005. All new children and youth in the Children's Mental Health system will a case manager-either from an existing agency, a family member, or from the Local Coordinating Council.

Criterion 1, Goal and Indicator 11: New Case Management Initiatives

To implement new program alternatives in the state that will have as part of their program design a strong case management component.

New state funds have been set aside for the following three service initiatives:

1. New in state NETWORK= 21 new slots. The NETWORK provides a “no reject, no eject” continuum of community based care to 205 youth, males and females, ages 13-21. The present NETWORK is composed of a consortium of five providers and the range of services includes: residential treatment, group home care, supervised apartment living, independent living, foster care and community based clinical services.

2. A new support, counseling mediation service for families involved with wayward youth has diverted 75% of the 500 families it has served from becoming involved in the Family Court System.

3. A new Truancy Court program is now available almost statewide; this system diverts truancy type cases to appropriate community based programming rather than to the Family Court for some type adjudication.

4. Two new residential treatment centers = 16 beds; hospital step down..

5. 23 new Therapeutic Foster Home slots.

6. Diagnostic Therapeutic Foster Homes; capacity 8 adolescents, provide emergency foster home and evaluation services.

Criterion 2: Prevalence and Treated Prevalence of Mental Illness

Criterion 2 requires states to estimate the incidence and prevalence of serious emotional disturbance among the state's children; and to present quantitative targets to be achieved in the implementation of the system of care described in Criterion 1.

Criterion 2, Goal and Indicator 1: Quantitative Targets for Services

In FY 2005 650 new cases will be reviewed by the local CASSP Case Review Teams.

An independent evaluation group that validates target achievement monitors the CASSP Review Team process on a monthly and yearly basis. The Department will continue to have three MSW level staff involved with the implementation of this Goal.

Criterion 2, Goal and Indicator 2: Services to Youth with SED

In FY 2005 , 18000 youth will receive Children's Intensive Services (CIS). These are children and youth who have Severe Emotional Disturbance (SED) and receive family/community based intensive therapy, case management and wraparound services.

The CIS program is monitored on a monthly, semi-annual, and annual basis for target achievement. The Department has a completely redesigned Utilization/Review Team in place to monitor the implementation of the "new" CIS. This program is undergoing a major transformation for FY 04 from a contracted program to a program, which will require any willing vendor to become a Certified provider. This transformation was totally completed by in May of 2004.

Criterion 2, Goal and Indicator 3: Reintegration via Project HOPE

The Project HOPE grant will service 150 new youth with SED who are returning to their communities from the juvenile correctional facility.

This process is monitored on a monthly basis through an evaluation contract DCYF maintains with the Yale Consultation Center.

Criterion 2, Goal and Indicator 4: In-State Treatment

To provide more in-state treatment beds.

A total of 132 new treatment beds will provide instate residential treatment options for children and youth in RI. These additional treatment beds will be monitored on a monthly basis using performance and outcome measures established within the contract.

Criterion 2, Goal and Indicator 4: Prevalence Rates of Children and Youth with Serious Emotional Disturbance (SED)

To refine determination of incidence and prevalence of severe mental disability in the child population in accordance with P.L. 102-321 requirements.

Using the data from the 2000 Rhode Island Kids Count Fact Book and statistics from Mental Health: A Report of the Surgeon General, 1999, Rhode Island has formulated the incidence and prevalence figures for youth with SED.

There are 224,981 youth in R.I. under the age of eighteen.

The Surgeon General's Report indicates one in five children and adolescents in our state would experiences the signs of a DSM -IV diagnosis. In R.I. that translates into a prevalence rate of 44,996.

The surgeon general's Report, page XV, goes on to state that "…only about 5 percent of all children experience what professionals term "extreme functional impairment". This 5% figure, 11,249 in R.I., is the incidence of youth with SED.

Criterion 3: Provision of Children's Service

According to block grant legislation, DCYF is statutorily required to provide comprehensive community-based services for children with SED in the following manner:

(A) Subject to subparagraph (B), provides for a system of integrated social services, educational services, juvenile services, and substance abuse services, which, together with health and mental

health services, will be provided in order for such children to receive care appropriate for their multiple needs. This system includes services provided under the individuals with disabilities education act;

(B) Provides that the grant under section 1911 for the fiscal year involved will not be expended to provide any service of such system other that comprehensive community mental health services; and

(C) Provides for the establishment of a defined geographic area for the provision of the services of such system.

Please refer to Section II, b, iii on page 48 for a detailed description of the array of Children's Services.

The following narrative describes the evaluation of the Project REACH RI service initiative, which started in October of 1995. This narrative is included here to give the reader a more clear picture of the community based integrated nature of the Children's Mental Health system in the State of Rhode Island for children who have SED.

The results of a Yale Consultation Center evaluation of RI's integrated community based system of care follows:

Systems of care provide comprehensive services to children with emotional Service Access and Service System Development and behavioral disorders through a network of local agencies and providers that function as a multi-agency case review team. A primary objective in any system of care is to provide individuals with access to appropriate services. In the present study, access is defined as services received relative to those recommended by a multi-agency review team and barriers to services identified by that team. These indicators, which provide a system-level assessment of service access and function as a proxy for the development of the system of care, fill a gap in the existing literature for more system-level indicators of outcome.

Demographic Characteristics of Children Entering the Rhode Island System of Care (N=2,073)

Characteristic	Overall Sample	
	Number	Percent
Gender		
Female	612	29.5
Male	1,461	70.5
Age		
5 years and younger	221	10.7
6 - 12 years old	1,012	48.8
13 - 15 years old	542	26.1
16 and older	298	14.4

Race/Ethnicity		
African American	255	12.3
American Indian/Alaskan Native	29	1.4
Asian/Asian American/Pacific	23	1.1
Islander	1,448	69.9
White	201	9.7
Hispanic	117	5.7
Other/Biracial		
Level of Functioning: C-GAS Scores		
0 - 40	290	14.0
41 - 60	1,570	75.7
61 - 100	213	10.3
Referral Source		
Mental Health Agency	854	41.2
School	397	19.2
Parent/Friend/Self	371	17.9
DCYF	126	6.1
Judicial Agency/Courts	93	4.5
Social Service Agency	69	3.3
Physician/Health Care	28	1.4
Professional	135	6.5
Other Sources		

*Considered in combination, theses cost-outcome findings involving children's behavior problems, global functioning, school attendance, and school performance suggest that, on a state-wide basis, resources are being allocated appropriately in accordance with children's need for services in the least restrictive setting.

This study shows that substantial positive changes in the development of a system of care are possible in less than eight years, and that two system-level measures of service access are useful indicators of those changes. Services received relative to those recommended and barriers to service as determined by a multi-agency review team represent critical system-level indicators of service access that were carefully monitored as the system of care developed over an almost 8-year period. Changes in these indicators across three assessment periods about two and one-half years apart provide evidence of significant system change toward ever increasing access over time. These changes in access were also reflected in increases in the number and types of children served and types of agencies involved in the system of care. These findings demonstrate that the effective implementation of system of care principles increases service access in a developing system of care, and that those changes can be monitored successfully through collection of system-level indicators. (J. Tebes, Ph.D., Yale University School of Medicine, 2004).

In 1998 the Department was awarded a second service implementation grant from CMHS- Project HOPE. This is a six year, $8.5 million service grant to enhance the community based mental health and other services available to all SED youth exiting the state's juvenile correctional facility.

MEAN AND STANDARD DEVIATION RATIOS OF SPECIFIC TYPES OF SERVICES

RECEIVED TO THOSE RECOMMENDED BY MULTI-AGENCY REVIEW TEAMS WITHIN 3

MONTHS OF THE INITIAL CASE REVIEW DURING THREE PHASES OF RHODE ISLAND'S SYSTEM OF CARE *(J. Tebes, PH.D., Yale University School of Medicine)*

(N=2,073)

Characteristic	Period 1 (N=256) Mean Ratio (Standard Deviation)	Period 2 (N=717) Mean Ratio (Standard Deviation)	Period 3 (N=1,100) Mean Ratio (Standard Deviation)
Mental Health Services	49.1 (40.8)	72.2 (35.1)	82.9 (29.1)
Social Services	51.4 (49.1)	65.0 (45.3)	82.6 (34.3)
Educational Services	55.5 (47.8	76.0 (39.9)	86.6 (31.8)
Operational Services	43.1 (47.9)	62.6 (45.5)	76.4 (39.4)
Recreational Services	24.1 (41.0)	61.7 (45.5)	65.7 (44.2)
Vocational Services	28.8 (45.1)	57.4 (48.3)	55.3 (48.8)
Health Services	40.5 (49.8)	72.6 (44.8)	85.2 (35.3)

Criterion 3 Goals

Goal 1

In FY 2005, current needs and gaps within each mental health service area will continue to be identified through the data collected on a monthly basis from an outside evaluator.

Goal 2

In FY '2005, all CIS clients and clients reviewed by the CASSP LCCs will have individual case plans developed which integrates social services, substance abuse services and health and mental health services. Providers of these services will be included in developing the case plans.

Goal 3

In FY '2005 there will be a continuation on the effort to identify LEAs who are not participating in the CASSP process and to recruit them into this process.

Goal 4

In FY '2005, interagency Memoranda of Agreement (MOA) for participation in Transitional Planning will continue to be fully implemented between the Department of Children, Youth and Families and the Department of Mental Health Retardation and Hospitals (MHRH). MHRH is the Department in the state charged with planning mental health services for adults. This will be the first full year of the implementation of this MOA. Quarterly transitional planning meetings between the two Departments have been implemented.

Criterion 3, Indicators

- The statewide CASSP process will continue to be funded and function at full capacity. In addition, this year $375,000 of State funds have been added to the CASSP infrastructure to fund new Enhanced CASSP Services. Enhanced CASSP Services are designed to provide a more intensive array of community-based wraparound services to children/youth who are at risk for hospitalization or high-end residential placement.
- Additional Federal Grants applications will be submitted for FY 05, as mentioned in a previous Section.
- Performance measures and outcomes for all the above programming will continue to be evaluated by an outside evaluator.

Set Aside for Children's Mental Health Services:

Below are two tables that describe how block grant and state funds are expended by state fiscal year:

BLOCK GRANT FUNDS EXPENDED

	Actual 2002	Actual 2003	Actual 2004	Estimated 2005
Admin/travel	500	1000	0	1000
Youth Pride, Inc.	85,000	85,000	88,000	88,000
State Systems Planner	NA	60000	24,997	57,000

System's Analyst	NA	NA	NA	60,000
Total	85500	146,000	112,997	206,000

STATE FUNDS EXPENDED

	Actual 2002	Actual 2003	Actual 2004	Estimated 2005
Integrated Services (CIS)	3.4 MIL	3.4 MIL	2.8 MIL	3.4 MIL
RCCs	669,312	2.8 MIL	3.4 Mil	3.4 MIL
ALP	130,000	132,000	132,000	132,000
ILP	413,000	608000	682,000	682,000
PSN	60,000	60,000	63,000	63,000
Day Treatment	1.02 MIL	1.02 MIL	1.02 MIL	1.02 MIL
Project CASSP*	4.1 MIL	5MIL	3.8Mil	3.44 MIL
Utilization Review	1.76 MIL	1. MIL	1. MIL	1 MIL
TOTAL STATE FUNDS	10,998,312	13,200,000,	12.18 mil	13.14 MIL

* Previously named Project REACH

The state figures above do not include state\Medicaid expenditures for high end Residential Treatment (POS) or hospitalizations. The Department anticipates funding POS at $21.7 million and $20 million for hospitalizations in FY 2005

In addition to this figure of $13.4 million in state funds, for community based\integrated mental health services from the Division of Children's Behavioral Health, the Department anticipates funding an additional $40 million for mental health related services from the budgets of the Department's two other operational divisions, Juvenile Corrections and Contracts Standards and Planning.

Criterion 4: Targeted Services to Homeless and Rural Population

The plan provides for the establishment and implementation of outreach to, and services for, such individuals who are homeless.

Criterion 4, Goal and Indicator 1: Maintain Services

The Department plans to continue to identify and provide services to homeless youth in the state.

- The Department will continue to partner with the Traveler's Aid and the Emergency Shelter Programs. These are statewide programs working directly with homeless youth in the state.
- The contracts are all monitored on a weekly, monthly and an annual basis for occupancy rates and for effectiveness through the Department's internal process.
- In addition the Department has 127 Emergency Shelter slots.
- The Department plans to fund an additional 67 in state residential care beds in FY 2005. The types of placements this number represents includes hospital step down residential , DD

residential, Group Homes, Supervised Apartments, Independent Living, and Foster Care. These are all programs which prevent homelessness by providing an array of residential placements for youth.

Criterion 4, Goal and Indicator 2: Homelessness Prevention

The Department will take steps to funds programs and services that are designed to prevent homelessness among the youth of the state.

- In FY 2005 the Department will fund an additional Residential Counseling Center to provide residential treatment for up to 8 youth who would otherwise be without a residential placement. The Department already funds over 1000 residential slots for youth who would have no other place to qualify as a home
- Provide temporary rental assistance and bus passes for a category of young single parents to get them 'started' on the road to independent living.

Criterion 4, Goals 3-5: Service provision to rural areas

The plan describes the manner in which health services will be provided to individuals residing in rural areas.

Goal 3

Use the data collected from the statewide system assessment completed by CASSP to identify service needs of the rural population.

Goal 4

Work with CIS providers to continue to develop in-home mental health treatment interventions that meet the needs of the rural population.

Goal 5

Recruit LEAs from rural areas for CASSP LCCs.

Criterion 4, Indicators for Goals 3-5: Service provision to rural areas

The results of all the above Goals will get monitored on a regular basis with the services of an outside evaluator.

Criterion 5: Management Systems

The plan describes the financial resources and staffing necessary to implement the requirements of such plan, including programs to train individuals as providers of mental health services, and the plan emphasizes training of providers of emergency health services regarding mental health.

Criterion 5, Goal and Indicator 1: Increased Services

In FY 2005, the stateplans to increase the array of community mental health services.

- A new Mobile Crisis Team will be established at a cost of $900,000 annually.
- The state legislature continues to allocate $200,000 to provide community based services for youth who are uninsured.
- Please review Section I New Initiatives, Children's Services: "New Program Initiatives," for a further description of new programs for FY 05, page 29.
- This will amount to a state funded Children's Behavioral Health budget for FY 05 of $13.14 million. The Work Plan for Children's Behavioral Health may be modified FY 05, since it has not yet been decided in which Division of the Department each of the new service initiatives will reside.

These programs and their budgets, which reflect an increase of state funding in the amount of 2.2 million, will be reflected in the FY 2005 DCYF Work Plan. Appropriate monitoring of performance and outcome measures will take place on a monthly basis.

Criterion 5, Goal and Indicator 2: Expenditure of Block Grant funds

The plan contains description of the manner in which the state intends to expend the grant for FY 2005 to carry out the provisions of the plan required in paragraphs (1) through (11).

To expend Block Grant Funds in accordance with the requirements of the P.L. 102-321.

As indicated in the responses under Criterion 1-5 goals and activities, FY-2005 Block Grant funds will be used in three categories to support the goals of the Criteria.

Proposed FY 2005 Children's Mental Health Block Grant Work Plan:

1. $88,000 for a program designed to provide outreach, support and Service Directory development for gay and lesbian youth in the State of R.I.
2. $43,000 will be set aside to act as collaborative "seed" money to assist with the start up cost associated with the hiring of a **State Systems Planner** to implement the Organized System of

Care For Children, Youth and Families- as described in the "DCYF Priorities for FY 2003-4" section of this submission.

3. $1000 will be reserved in a separate line item for administrative expenses. These expenses are for travel and meeting expenses mandated by the grantor, but not funded. Any portion of this line item not utilized during FY 05 will be re-programmed back to assist in the funding of the state planner.

4. $60,000 in carry over funds will be re-programmed to fund the services of a systems analysis of the developmental progress of RI's System of Care.

Criterion 1 Mental Health Performance Indicator Statistics

STATE MENTAL HEALTH PLAN FY 2005 PERFORMANCE INDICATORS

Population: SMI Adult or SED Children (Circle one)

Criterion I: Comprehensive, Community-Based Mental Health System

(Please start a new page for each of the criteria.)

Performance Measures:	FY 2003	FY 2004	FY 2005	%
	Actual	Actual	Objective	Attain
1. Out of home Placements - in state				
Value:	135	141	110	NA
IF Rate:				
Numerator				
AND				
Denominator				
2. Out of Home Placements - out of state				
Value:	132	106	42	NA
IF Rate:				
Numerator				
AND				
Denominator				
3. Diversion from Residential Care (CASSP Case Reviews)				
Value:	81	81	80	NA
IF Rate:				
Numerator				
AND				
Denominator				
4. Service Network	NA	163	205	
5. Dev. Dis. Community Residential Beds	NA	0	8	

Criterion 2 Mental Health Performance Indicator Statistics

STATE MENTAL HEALTH PLAN FY 2005

PERFORMANCE INDICATORS

Population: SMI Adult or SED Children (Circle one)

Criterion 2: Prevalence/treatment Prevalence - SED Youth

(Please start a new page for each of the criteria.)

Performance Measures:	FY 2003	FY 2004	FY 2005	%
	Actual	Actual	Objective	Attain
1. CASSP Case Reviews				
Value:	650	650	650	NA
IF Rate:				
Numerator				
AND				
Denominator				
2. CIS clients				
Value:	2220	2,200	1,800	NA
IF Rate:				
Numerator				
AND				
Denominator				
3. Incidence of SED				
Value:	11,249	11,249	11,249	NA
IF Rate:				
Numerator				
AND				
Denominator				

Criterion 3 Mental Health Performance Indicator Statistics

PERFORMANCE INDICATORS

Population: SMI Adult or SED Children (Circle one)

Criterion 3: Integration of Children's Services

(Please start a new page for each of the criteria.)

Performance Measures:	FY 2003	FY 2004	FY 2005	%
	Actual	Actual	Objective	Attain
1. Individual CIS Case Plans				
Value:	1,300	2,200	1800	NA
IF Rate:				
Numerator				
AND				
Denominator				
2. HOPE Case Plans (new)				
Value:	120	125	150	NA
IF Rate: Number of SMI Clients Who are Homeless				
Numerator				
AND Total Number of SMI Clients Served				
Denominator				
3. Hospital Diversion:				
Value:	NA	45	19	NA
4. Out of State Placements:				
Value:	NA	100	42	NA

Criterion 4 Mental Health Performance Indicator Statistics

STATE MENTAL HEALTH PLAN FY 2005

PERFORMANCE INDICATORS

Population: SMI Adult or [SED Children] (Circle one)

Criterion 4: Target Services to Homeless-SED Youth

(Please start a new page for each of the criteria.)

Performance Measures:	FY 2003	FY 2004	FY 2005	%
	Actual	Actual	Objective	Attain
1. Traveler's Aide Runaway				
Value:	100	100	100	NA
IF Rate:				
Numerator				
AND				
Denominator				
2. * Emergency Shelters - slots				
Value:	140	126	127	NA
IF Rate:				
Numerator				
AND				
Denominator				

* The number of dedicated Emergency Shelter slots shows a decrease from FY 03 because the Department has programmed approximately 20 beds from the Emergency Shelter designation to allow them to be part of the three Service Networks that are in operation. So the total capacity has not decreased over the past two fiscal years, but some of the emergency Service slots are allocated to children/youth who are in one of the three Service Networks as part of the continuum of care for the Networks.

Criterion 5 Mental Health Performance Indicator Statistics

STATE MENTAL HEALTH PLAN FY 05 PERFORMANCE INDICATORS

Population: SMI Adult or SED Children (Circle one)

Criterion 5: Management Systems, SED Children

(Please start a new page for each of the criteria.)

Performance Measures:	FY 2003	FY 2004	FY 2005	%
	Actual	Actual	Objective	Attain
1. New/Additional State Program Funding				
Value:	2.1MIL	2MIL	2.2 MIL	NA
IF Rate:				
Numerator				
AND				
Denominator				
2. Project Hope - Federal Grant				
Value:	1.5 MIL	2 MIL	2 MIL	NA
IF Rate:				
Numerator				
AND				
Denominator				

Attachments

Attachment A: Funding Agreements

Attachment B: Certifications

Attachment C: Assurances

Attachment D: Disclosure of Lobbying Activities